

Nebraska Women's Health Strategic Plan 2004 - 2010

New Dimensions of Health for Nebraska Women Project



Fall 2004

For more information regarding the New Dimensions Partnership, please contact:

Nebraska Office of Women's Health
Nebraska Department of Health and Human Services
PO Box 94817
Lincoln, NE 68509-4817

Diane Lowe

diane.lowe@hhss.ne.gov

402-471-2772

This publication was supported by Cooperative Agreement Number H74MC00024 from the Health Resources and Services Administration. Its contents are solely the responsibility of the authors and do not necessarily represent the official view of the Health Resources and Services Administration.



Nebraska Women's Health Strategic Plan

2004 ~ 2010

Richard Raymond, M.D., Chief Medical Officer
Nebraska Health and Human Services System

Kathy Ward, Administrator
Office of Women's Health

Paula Eurek, Administrator
Office of Family Health

Office of Minority Health

Project Consultants:
Patricia Funk, Ph.D.
Strategic Health Concepts
Nebraska Minority Public Health Association

Production & Formatting of Plan:
Diane Lowe, Community Health Educator
Office of Women's Health

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



Acknowledgments

The Nebraska Women's Health Strategic Plan is the result of a statewide collaborative initiative, designed to improve the state's women's health care delivery system. The plan was developed through the generosity of many organizations and individuals committing their time, expertise, and other resources.

Women's Health Advisory Council

The Nebraska Women's Health Advisory Council convened the New Dimensions of Health for Nebraska Women Partnership. The Council sponsors the Partnership, and is responsible for planning, partnership building, and implementation activities.

Olga Caicedo, Lincoln
Joan Cromer, Gering
Marie de Martinez, Grand Island
Dr. Diana Doyle, Omaha
Paula Eureka, Lincoln
Takako Faga, Lincoln
Mary Jo Gillespie, Lincoln
Lisa Good, Lincoln
Dr. Karen Higgins, Grand Island
Dr. David Holdt, Scottsbluff
Senator Jim Jensen, Lincoln
Kate Kulesher, Lincoln
Kathleen Kock, Omaha
Anne Liska-Lambert, Wayne
Marilyn McGary, Omaha
Lola Medina, Niobrara
Dr. Debra Mostek, Omaha
Mary J. O'Gara, AARP Board of Directors
Carol Packard, Ogallala
Dr. Magda Peck, Omaha
Dr. Richard Raymond, Lincoln
Laura Redoutey, Lincoln
Mary Scherling, Beatrice
Senator DiAnna Schimek, Lincoln
Sheryl Schrepf, Lincoln
Rhonda Seacrest, Lincoln
Dr. Janice Twiss, Omaha
Judy Ueda, Omaha
Lori Vrtiska Seibel, Lincoln

New Dimensions of Health for Nebraska Women Partnership

The New Dimensions of Health for Nebraska Women Partnership guided the development of the Nebraska Women's Health Strategic Plan by developing their own short- and long-term objectives to complement those developed by the Internal Stakeholders.

Connie Benjamin, American Association of Retired Persons
Bridget Wieczorek, American College of Nurse Midwives
Dr. William Minier, Blue Cross Blue Shield of Nebraska
Dr. Janet Grange, Breast Surgeon
Jacque Cook, Charles Drew Health Center
Audrey Paulman, CIMRO Nebraska
Cindy Treffer, CIMRO Nebraska
Dr. J. Christopher Gallagher, Creighton Women's Community Health Center
Dr. Mary Jo Hanigan, Douglas County Community Mental Health Center
Pat Brown, Interchurch Ministries of Nebraska
Arlene Rea, Lincoln Education Association
Kim Carpenter, Nebraska Coalition for Women's Treatment
Marcie Lechtenberg, Nebraska Commission on the Status of Women
John Dahm, Nebraska Correctional Center for Women
Kathy Corbett, Nebraska Department of Corrections
Kristin Houser, Nebraska Domestic Violence Sexual Assault Coalition
Sarah O'Shea, Nebraska Domestic Violence Sexual Assault Coalition
Amy Adams, Nebraska Hospital Association
Dr. Diana Doyle, Nebraska Medical Association - Women's Section
RoseAnn L'Heureux, Nebraska School Nurses Association
State Senator DiAnna Schimek
Kathy Kniefl, Nebraska WIC Association
Jeanie Bohnenkamp, One World Community Health Center
Jan Fitts, Panhandle Community Services
Terry Krohn, Public Health Association of Nebraska
Linda Boeckner, University of Nebraska Cooperative Extension
Dr. Carl Smith, UNMC Olson Center for Women's Health
Dr. Donna Polk-Primm, Urban Indian Health Center

Internal Stakeholders

Representatives of programs within the Nebraska Health and Human Services System met to discuss their current projects as they relate to women's health and how they may work together to improve women's health services across Nebraska. The group identified short- and long-term opportunities for integration.

Linda Henningsen, Adolescent Health Program
Mary Jo Iwan, Aging & Disability
Kimberly Barrett, Cardiovascular Health Program
Marvie Sullivan, Child Care Licensing
Barb Packett, Commodity Supplemental Food Program
Steve Frederick, Data Management
Mary Gordon, Developmental Disability Planning
Kathy Goddard, Diabetes Control Program
Dan Cillessen, Disease Prevention & Health Promotion
Mike Harris, Economic Assistance
Betty Medinger, Economic Assistance
Darryl Wusk, Economic Assistance
Michelle Heffelfinger, Every Woman Matters
Melissa Leypoldt, Every Woman Matters Program
Paula Eurek, Office of Family Health
Tina Kruthoff, Office of Family Health
Julie Reno, Office of Family Health
Jacquelyn Miller, Health Surveillance
Barbara Ramsey, Lincoln Regional Center Mental Health Service
Susan Fiero, Medicaid
Linda Wittmuss, Office of Mental Health, Substance Abuse & Addiction Services
Nettie Grant-Sikyta, Office of Minority Health
Marilyn McGary, Office of Minority Health
Carol Simons Williams, Perinatal, Child, and Adolescent Health
Shirley Pickens-White, Protection & Safety
Sue Medinger, Office of Public Health
Sue Semerena, Public Health Assurance
Julia Schmitt, Radiation Control Program
Maria Diaz, Refugee Resettlement Program
Adrian Meuse, Reproductive Health Program
Dennis Berens, Office of Rural Health
Sandy Klocke, Ryan White Title II HIV/AIDS Program
Tammie Scholz, State Unit on Aging
Bryan Rettig, Strategic Management Services
Shirley Deethardt, Tobacco Free Nebraska
Peggy Trouba, Supplemental Nutrition Program for Women, Infants, & Children
Diane Lowe, Office of Women's Health
Kathy Ward, Office of Women's Health

Special thanks go to the Nebraska Women and Girls who provided their opinions and experiences for the surveys, community forums, and focus groups.

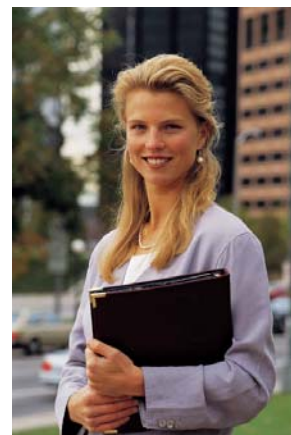


Table of Contents

Executive Summary	i
Introduction.....	1
Rationale	1
Plan Development Process.....	2
Needs Assessment: Data Review	5
Health Status Indicators	5
Behavioral Health and Violence against Women	10
Health Care Needs and Barriers for Women with Disabilities	14
Health Service Gaps for Low-Income Women.....	15
Needs Assessment: Voices of Nebraska Women and Girls.....	19
Voices from the Nebraska Women’s Health Survey	19
Voices of Women of Color	25
Voices from the Nebraska Girls’ Health Survey	31
Guiding Principles and Goals	36
Guiding Principles	36
Priority Goals.....	37
Women’s Health Program Challenges for State Government	38
Program Challenges.....	38
Integrating Women’s Health Programs and Services	40
Priority Health Issues and Strategies	41
Isolation within the Overall Health Services System	41
Inadequate Access to Culturally and Linguistically Appropriate Health Services....	45
Stigma, Fear, and Taboos around Certain Health Issues	50
Lack of Mutual Support Systems for Women	52
Inadequate Funding.....	55
Plan Implementation	58
First Year Action Steps.....	58
Action Steps for Years Two through Five	59
Evaluation	60
Continuity	61
Resources	62

Executive Summary

The outcome goal of the New Dimensions of Health for Nebraska Women Project is healthier women in Nebraska, in all populations. The Nebraska Women's Health Plan is a comprehensive strategy for achieving that goal. The Nebraska Health and Human Services System (NHHSS) developed the Plan in collaboration with the New Dimensions of Health for Nebraska Women Partnership (New Dimensions Partnership), a volunteer coalition of public and private agencies concerned with women's health. This initiative has been supported by a grant from the U.S. Health Resources and Services Administration.



Priority Goals and Issues

The following Nebraska 2010 Health Goals and Objectives were selected as priorities for Nebraska women's health:

- Access to Quality Health Care
- Education and Community-Based Programs
- Mental Health and Mental Disorders
- Nutrition and Overweight
- Physical Activity and Fitness

There are a number of interconnected issues that get in the way of reaching the goals for Nebraska women's health listed above. The following issues were selected as priorities to be addressed:

- Isolation within the overall health services system
- Inadequate access to culturally and linguistically appropriate health services
- Lack of mutual support systems for women
- Stigma, fear and taboos around certain health issues
- Inadequate funding

Strategies to Address Priority Health Issues

NHHSS and the New Dimensions Partnership identified a number of short-term and longer-term strategies to address the priority health issues for Nebraska women. These strategies are summarized below.

Reduce Isolation within the Overall Health Services System

Health services in Nebraska generally suffer from “systemic isolation.” Instead of being comprehensive and integrated, services are fragmented and segregated.

- Redefine local/regional health departments as Community Health Departments.
- Develop partnerships among service providers.
- Increase awareness of community resources for women’s health needs.

Increase Access to Culturally & Linguistically Appropriate Health Services

The current health system tends to “lock out” or limit access for certain groups because they cannot readily obtain the appropriate services they need. Access to appropriate services can be limited by language, race, ethnicity, culture, gender, age, sexual orientation, and disability status.



- Put services where people live and work that are reflective of the local cultures.
- Increase the number of racial/ethnic minority and rural health care providers.
- Educate providers about the cultural dimensions of healthcare and encourage the implementation of CLAS standards (Culturally and Linguistically Appropriate Services).

Reduce Stigmas, Fears & Taboos

There are a number of health problems that have historically carried a stigma in our society. There are other health issues for which there are strongly-held, differing viewpoints that in some instances have become so polarizing that civil discussion and debate are often stifled.

- Increase the level of discussion and awareness on women’s health issues affected by stigmas and taboos.
- Encourage and enable providers to address the broad array of women’s health issues more fully.

Increase Women’s Mutual Support Systems

Many Nebraska women have indicated the need for more women’s mutual support groups that allow those with similar health issues to connect with and support each other.

- Engage and assist communities to develop and improve mutual support systems for women's health.
- Identify and expand on existing health support systems and models throughout the state.

Improve Funding

Inadequate funding is a primary obstacle to meeting our health goals and objectives for women in Nebraska.

- Develop an integrated approach to the use of existing resources.
- Make a case for new resources for women's health.

Plan Implementation



Implementation of the Women's Health Plan requires specific actions to carry out the strategies that were identified to address priority issues and help achieve its goals. The following action steps pertain to the Nebraska Health and Human Services agency, often in collaboration with members of the New Dimensions Partnership.

First Year Action Steps

- Inventory financial resources and available categorical funding streams of programs within the Nebraska Health and Human Services agency to find common priorities related to the Culturally and Linguistically Appropriate Services requirements.
- Inventory priority issues of Nebraska Health and Human Services agency programs to determine corresponding goals and priorities. Develop a matrix of opportunities and a coordinated action plan and financial plan.
- Fund three pilot communities to develop integrated, coordinated women's health services that include initiatives to identify and further develop support systems for women, develop best practices and improved service linkages, disseminate women's health promotion messages, and develop shared expectations and standards for cultural competence.

- Create a central information source on women's health interpreters and translators (language, vision, and hearing impaired) for all programs to access.
- Develop a campaign to help women understand how to advocate for high quality health care for themselves.

Action Steps for Years Two through Five

- Create and disseminate resources to provide technical assistance and increase communication between the Nebraska Health and Human Services System and local health departments, health care providers, and other organizations providing services to women.
- Develop a comprehensive web-based Community Resource Directory. Disseminate information on the Directory to women throughout the state.
- Organize a state task force to develop a web-based confidential screening tool for health referrals, with links to local resources.
- Increase the availability of support groups for women on various health issues, and expand walking groups for women as a way of providing mutual support.
- Incorporate a wellness program into a living unit at the women's prison and evaluate the program.
- Organize a publicity campaign on women's health issues.



INTRODUCTION



The outcome goal for the New Dimensions of Health for Nebraska Women Project is healthier women in Nebraska, in all populations. This will be achieved through a statewide partnership of public and private organizations that will build a sustainable infrastructure for improved and expanded women's health services. The foundation for this infrastructure is the Nebraska Women's Health Plan, described in this document.

Rationale

Nebraska's public health system has historically been fragmented and poorly funded. The result has been a lack of infrastructure on which to build preventive health services for women. In a dramatically changing environment, Tobacco Settlement Funds are being utilized to develop a comprehensive statewide local public health system. This is occurring at the same time that Nebraska, a previously homogeneous state demographically, is becoming increasingly diverse through rapid expansions in foreign-born and native minority populations. These two factors combine to make this an enormously important time and opportunity to expand coordination and capacity for women's health services in the state.

Current services for women in the Nebraska Health and Human Services System (NHHSS) are primarily supported by federal funds. Staff from the categorical programs have had to concentrate on satisfying requirements of individual funders. No opportunity has been available to bring all programs together to compare data systems and eligibility requirements, to develop a

database of referral sources and linkages for women, or to assist women's access to a whole range of preventive services and comprehensive health education. Each program has its own individual standards, frequently based on the requirements of the funders. NHHSS has the opportunity to increase the reach and efficiency of individual programs by pooling resources and increasing communication. The need exists to integrate women's health needs with services and resources available in order to develop comprehensive integrated women's health services system.

"When I told my doctor my problems, he asked if my periods were regular. When I answered affirmatively, he said, 'then you're ok.'"
- Nebraska Women's Health Survey Respondent

All NHHSS programs and Nebraska health programs that are community based share a need to appropriately address the provision of culturally competent, linguistically appropriate services to the state's increasingly diverse population. They also share a need to ensure that all women have

access to the services they need in a seamless system of women's health care.

This project is a collaborative effort within NHHSS among the Office of Family Health, the Office of Women's Health, and the Office of Minority Health; funded by a three-year grant from the U.S. Health Resources and Services Administration (HRSA). The Governor's Women's Health

Council has convened a Partnership composed of organizations throughout the state that provide health-related services to women. The New Dimensions of Health for Nebraska Women Partnership has worked in conjunction with NHHSS project staff to help develop the Nebraska Women's Health Plan, and its members perform a critical role in the implementation of this plan.

Plan Development Process

The development of the Nebraska Women's Health Plan has entailed three major components: a needs assessment and two strategic planning processes, one internal to state government and one external.

Needs Assessment

The needs assessment process resulted in a number of discrete reports distributed throughout the entire planning process, most of which were available prior to the first external planning session. The components included Nebraska data related to a number of women's health topics, including mortality, chronic health conditions, health risk factors, mental health, substance abuse, domestic violence, and sexual assault. The needs assessment also examined the health services gap for low-income and minority women in terms of participation in important women's health programs: Medicaid, Title X family planning programs, and the Every Woman Matters health screening program.

In addition to the statistical data, information on health issues was gathered directly from Nebraska women in four separate ways: a Nebraska Women's Health Survey, a Nebraska Girls' Health Survey, a series of focus group meetings for racial/ethnic minority women in different areas of the state, and a town hall meeting on health issues for minority women.

A summary of the needs assessment document is included in this document. Copies of the full report are available from the Nebraska Office of Women's Health.

*"I'm dissatisfied with wheelchair access to doctor, dentist, eye clinic, etc.—is often ok to get in the building but the offices are too small to accommodate my chair."
-Nebraska Women's Health Survey Respondent*

Strategic Planning Sessions

An internal strategic planning meeting on May 20-21, 2003 in Lincoln, Nebraska brought together representatives of approximately 40 programs in the Nebraska Health and Human Services System that relate to women's health. The purpose of the meeting was to identify ways to enhance women's health programming through better internal integration and coordination.

Prior to the meeting, summaries were obtained for each program that identified its purposes related to women's health, its specific services and benefits, the target population, eligibility criteria, numbers served, access points, women's health messages and guidelines, major program partners, types and amounts of resources, biggest challenges, issues regarding linguistic and cultural competence, major gaps, and opportunities for internal integration and coordination. Based on these summaries, which were distributed and reviewed during the first meeting day, participants identified a number of commonalities and challenges across programs. They were also given a review of available needs assessment data.

The major outcomes of this internal strategic planning meeting were the identification and prioritization of short-term integration opportunities and the identification of a number of longer-term opportunities. These outcomes are described in the issues and strategies section of this document. The participants in the internal planning meeting also made a number of recommendations for the overall planning process, accountability and evaluation, and the plan's dissemination and marketing.

The external strategic planning process was conducted in Lincoln in two sessions on August 26, 2003 and October 14, 2003. The participants were representatives of women's health-related programs and services outside the Nebraska Health and Human Services System, who agreed to participate in the New Dimensions of Health for Nebraska Women Partnership. Approximately 40 individuals participated in the planning sessions.

Prior to the first meeting, participants were sent a list of health goals from the Nebraska 2010 Health Goals and Objectives, and a set of needs assessment documents. They were asked to complete a pre-meeting worksheet based on a review of the goals and data, as well as their own expertise and experiences. The worksheet solicited ideas on priority goals, top health issues for women, disproportionate population burdens,



contributing factors, potentially effective strategies, and opportunities for collaboration.

The principal results of the first session were the selection of five priority goals, the identification and prioritization of issues that need to be addressed to reach those goals, and the development of a number of strategies to address the priority issues.

The second external planning session resulted in the refinement of the priority issues and strategies, the identification of a

number of guiding principles for the plan, and some initial action steps. The output of these two sessions are reflected in the Priority Goals, Issues, and Strategies, and Plan Implementation sections of this document.

Copies of the internal and external strategic planning session materials and reports are available from the Nebraska Office of Women's Health. Lists of the participating individuals and programs are included in the Acknowledgments.

"It seems we need to see and hear very often how it's to our advantage to take care of ourselves. We get busy and living takes over our time and we forget to take care of ourselves until we get sick or in pain."

-Nebraska Women's Health Survey Respondent

Needs Assessment: Data Review

The data portion of the needs assessment drew on numerous published statistics and government-supported health program reports. The following is a summary of the most pertinent findings. The full needs assessment is available from the Nebraska Office of Women's Health.

Health Status Indicators

Mortality

Heart disease and stroke are the leading causes of death for women in Nebraska, while diabetes is a major contributing cause (see Table 1). Chronic lower respiratory diseases (including bronchitis, emphysema, asthma, and others), lung cancer, and breast cancer are the third through fifth leading causes of death. Nebraska women have slightly lower age-specific mortality rates overall than women nationally. This advantage applies to each of the above leading causes of death.

Racial/ethnic background is a major factor in health status and leading causes of death (see Table 2). Heart disease is the leading cause of death for women in Nebraska across all racial/ethnic groups, although the relative risk varies. Differences in heart disease mortality rates are the primary reason for differences in overall mortality rates among the groups. Native American and Black women have substantially higher mortality rates overall than White women. Asian and Hispanic women have much lower mortality rates. This pattern is true at the national level as well.

Native American women have the poorest health status among the major racial/ethnic groups in Nebraska and are twice as likely to die each year than White women. Cirrhosis is the third leading cause of death for Native American women, causing deaths at a rate nearly 14 times as high as for White women in Nebraska. Native American women are four times more likely to die from diabetes-related causes than their White counterparts and are also much more likely to die from unintentional injuries and heart disease.

Black women also have substantially higher mortality rates in Nebraska than White women. Their greatest increased risks are for diabetes-related causes, cirrhosis, stroke and heart disease. They have a moderately elevated risk of deaths from lung cancer and breast cancer.

Hispanic women have lower risks of mortality than White women in Nebraska from all major causes except cirrhosis and diabetes-related causes. Asian women in Nebraska have lower risk for all causes of death for which reliable data could be obtained.

Table 1. Leading Causes of Death for Nebraska Women, 1997-1999

Cause of death	Nebraska women's mortality rate*	National women's mortality rate*	Annual average deaths of Nebraska women
All causes	689	736	7,949
Heart disease	199	221	2,464
Diabetes (related cause)	62	68	691
Stroke	58	62	728
Chronic lower respiratory diseases	35	37	384
Lung cancer	34	41	329
Breast cancer	25	28	252
Unintentional injuries	25	23	259
Alzheimer's disease	20	17	271
Influenza and pneumonia	20	21	253
Colorectal cancer	18	18	198
Diabetes (underlying cause)	17	23	182

* Mortality rates are per 100,000 women, 1997-1999 annual average, all ages, age-adjusted to the 2000 U.S. standard population.

Table 2. Nebraska Women's Relative Mortality Risk for Selected Causes by Racial/Ethnic Group, 1994-1998

Cause	Mortality Risk Relative to White Women			
	Black	Native American	Asian/Pacific Islander	Hispanic ^a
All causes ^b	1.6	2.1	0.5	0.6
Heart disease	1.5	1.7	0.3	0.5
Diabetes-related	2.8	4.1	-	1.6
Stroke	1.6	0.9	0.8	0.3
Chronic lower respiratory diseases ^c	0.6	0.6	0.3	0.4
Lung cancer	1.3	0.9	-	0.4
Breast Cancer	1.3	-	-	-
Unintentional injuries	0.8	2.0	0.8	0.7
Cirrhosis	2.5	13.9	-	2.9

^amay be of any race

^bbased on 1997-1999 data

^cbased on 1997-1999 national data

Disparities in mortality rates are reflected in estimated life expectancies. A White female born in Nebraska during the years 1996 to 1998 can expect to live 80.7 years on average, compared to 72.8 years for a Black female and 72.3 years for a Native American female. These statistics are not available for other racial/ethnic groups.

Chronic Health Conditions

Some chronic health conditions are not directly reflected in mortality statistics but they can have a negative impact on functionality and quality of life. Two of these, arthritis and osteoporosis, are most likely to affect older women, although arthritis can occur at any age.

Arthritis

One-third (33%) of Nebraska women and more than half of those age 65 and older reported they had been diagnosed with arthritis or had joint symptoms consistent with that disease (BRFSS 1999-2000). Only one-third of those diagnosed with arthritis were currently being treated for the disease. Half of the respondents with joint symptoms reported that their physical activities had been limited for at least one month during the past year.

The risk factors for osteoarthritis, the most common form, include an inherited predisposition, joint injury, increasing age, female, African American (for activity limitation), rural residence, low household income, low level of education, participation in different types of sports, certain occupations requiring kneeling or squatting and heavy lifting, and being overweight (Nebraska 2010 Health Goals and Objectives).

Osteoporosis



“Osteoporosis is not part of normal aging although many people continue to believe this is true” (*America’s Bone Health*, National Osteoporosis Foundation report 2002). Osteoporosis and low bone mass were a health threat for nearly 200,000

Nebraska women in 2002 based on estimates by the Foundation. This “silent” disease usually progresses without symptoms until a bone fracture occurs. The national

prevalence rates for bone fractures indicate that 1 in 2 White women age 50 and older can be expected to have a bone fracture in their remaining lifetime, compared to 1 in 8 men of that age.

Non-Hispanic White and Asian women have much higher rates of osteoporosis and low bone mass than Black or Hispanic women, with nearly three-fourths (72%) at risk (see Table 3). This is also true for low bone mass, but the differences are not as great. Black women have the lowest prevalence rates, although 40 percent are still at risk.

Table 3. Osteoporosis and Low Bone Mass Prevalence Rates for U.S. Women Age 50 and Older by Race/Ethnicity

Race/ethnicity	Osteoporosis	Low Bone Mass	Total Risk
Non Hispanic, White or Asian	20%	52%	72%
Black	5%	35%	40%
Hispanic	10%	49%	59%

Diabetes

Diabetes is a serious chronic disease that is an underlying or related cause of more than 10 percent of Nebraska women's deaths annually. It also presents the risk of serious, debilitating conditions, including amputations and blindness.

The diagnosed diabetes prevalence rate among Nebraska women is estimated to be 5 percent based on the 1999-2000 BRFSS. However, experts believe that only half of diabetes cases are diagnosed. Nebraska women of color, except for Asian women, are more likely to have diabetes than their White counterparts, especially Native American women who have rates more than three times as high and Black women who have rates nearly double that of White women (see Table 4).



Table 4. Age-Specific Prevalence of Diagnosed Diabetes by Race/Ethnicity for Nebraska Women, Ages 45-64, 1997-2001

White	Black	Native American*	Asian*	Hispanic
6.8%	12.9%	23.6%	6.0%	7.7%

**Note: The statistics for these population groups are based on very small numbers.*

Asthma

Asthma is a serious, chronic disease that causes inflammation of the airways and restricts breathing. An estimated 11 percent of Nebraska women have asthma, similar to national rates for women. Although the asthma mortality rate is relatively low for Nebraska women (2.7 per 100,000) compared to the leading causes of death, it is substantially higher than the national rate (2.0).

HIV/AIDS

Acquired Immune Deficiency Syndrome (AIDS) is a life-threatening condition caused by the HIV virus. In Nebraska, women account for 13 percent of the 1,092 cumulative AIDS cases since the beginning of the epidemic, compared to 17 percent nationally. However, females accounted for 27 percent of the 79 new AIDS cases in 2000, up from just 10 percent in 1995.

Black women were much more likely than White women to die from AIDS in the years 1994 to 1998. No Hispanic women died of AIDS during that period. These statistics are not available for other racial/ethnic groups.

Health Risk Factors

Most of the leading causes of mortality and chronic conditions for Nebraska women identified in the preceding sections of this report are diseases for which the risks can be reduced through behavioral measures: healthy diet, appropriate exercise, not smoking, and not abusing alcohol or other substances. The probability of effective treatment or cures for many diseases is increased when there is early diagnosis as a result of screening procedures and other routine health examination services. The Behavioral Risk Factor Surveillance System (BRFSS) provides an overview of the health risk behaviors of Nebraska adults overall and for selected demographic groups.

The results of the BRFSS 1999-2000 report raise a number of concerns regarding Nebraska women's health. Of particular concern is the finding that 48 percent of

Nebraska women are overweight or obese, increasing their risk of diabetes, heart disease, arthritis, and other serious or chronic diseases. Contributing to and compounding the problem is the lack of regular and sustained exercise by 80 percent of women in the state.

Many women are not getting the types of health screenings that could detect serious diseases at an early stage. Nearly three-fourths of women age 50 and older (71%) had never had a blood stool test. More than a third of women (35%) had not had their cholesterol checked in the past 5 years. One-fifth (22%) of all women had not had a Pap smear in the past 3 years, including one-sixth (16%) of those who had not undergone a hysterectomy. Based on the 1998-2002 BRFSS, African American women (83%), Native American women (78%), and Hispanic American women (77%) were more likely than Nebraska women in general (77%) to report having a Pap test within the past two years.

More than one-fourth of women (29%) age 40 and older had not had a mammogram in the past 2 years. For African American women, the percentage was 32 percent; for Hispanic American women, 39 percent had

"I work two jobs and I am a full-time student. I can't afford medical insurance; Medicaid doesn't want to help you. I get my door closed just because I can't work an extra two hours."

- Nebraska Focus Group Respondent

not had a mammogram in the past 2 years. This compares with 28 percent of White women.

In the past year, nearly one-fourth of Nebraska women had not had a routine doctor's exam (23%) or had not seen a dentist (25%). The 1998-2002 Nebraska BRFSS found that Native Americans (78%) and African Americans (76%) were somewhat more likely to have had a routine

checkup in the past year than all Nebraskans (68%) and White Nebraskans (68%). Asian Americans (67%) and Hispanic Americans (58%) were less likely to have a routine checkup in the past year.

In most of these areas, considerable progress will have to be made in order for Nebraska women to reach the state health goals for 2010.

Behavioral Health & Violence against Women

Mental Health

Mental illness is a serious problem for women in Nebraska. It ranks second only to cardiovascular conditions in the level of disease burden in the United States and other countries with similar economies, according to international studies.

A 2001 report by the Division of Mental Health, Substance Abuse and Addiction Services of the Nebraska Department of Health and Human Services (the Division) provides estimates of the prevalence of serious mental illness (SMI) among adults and serious emotional disturbance (SED) among children for the lower-income Nebraska population (< 300% poverty level). The report also provides the rates of access to public sector mental health services for those estimated to have serious mental disorders. The public sector was defined to include the Division (contracted providers and Regional Centers) and Medicaid.

An estimated 8 percent of all lower-income females in Nebraska have serious mental health problems, compared to 6 percent of

lower-income males. That translates to 38,821 females in the year 2000 in need of public sector mental health services. The number of women served by the public sector mental health system that year was 22,602, or 58 percent of those with SED or SMI (excluding substance abuse treatment). By contrast, the comparable access to care rate for males was 74 percent.

The report provides access to care rates for each of the six health regions by sex. Access to care rates were highest for females in the central (72%) and southeast (70%) and lowest in the north (41%) and east (49%) regions. In the middle were the west (56%) and southwest (66%). Males showed a similar regional pattern, but with higher rates than females in each region.

The access rate for all lower-income persons, both male and female,



with SMI or SED was 65 percent. Those over age 65 had much lower rates than others: only 18 percent of the elderly with serious mental disorders received public mental health services.

Overall, racial/ethnic minority group members had lower access rates (55%) than those who were White, non-Hispanic (63%). However, the disparity had a strong regional pattern: racial/ethnic minority group members had much lower access rates than others in every region except the southeast, where there was no difference, and in the east, where minority group members had somewhat better access rates than others.

The results indicate a sizeable unmet need for public mental health services. Division officials report that the current capacity for public mental health services is inadequate to meet consumer demand and, consequently, there are extensive waiting lists for services. The greatest area of unmet need is for non-residential services. One problem is the increasing number of individuals who lack adequate insurance coverage.

There are no clear explanations for why lower-income women are less likely to access services than their male counterparts. Many respondents to the Nebraska Women's Health Survey (NHHSS, 2003) noted that time is a major obstacle in accessing health services. Compounding the time constraints are the general lack of

childcare facilities at treatment centers. Women who are family caregivers face serious obstacles to entering residential treatment, including the possible loss of custody of their children. The stigma of mental illness prevents many from seeking treatment. The question as to whether this is a greater obstacle for women than for men still remains.

The very low access rate for those over age 65 is consistent with national studies showing that the elderly who have mental health problems are less likely than others to seek professional help. One likely reason is cost. Although many have Medicare, it covers only half of mental health services and does not cover prescription drugs. Other reasons that have been cited include: stigma, denial of problems, access barriers, funding issues, lack of collaboration and coordination between mental health and aging networks, and shortages of appropriate health professionals (American Association for Geriatric Psychiatry, 2002).

"The clinic should have more case managers to come to our homes. Because sometimes when you go to the doctor's office you don't feel so secure to talk, and not be nosey. It's easier to talk at home like the public health departments, who have nurses who come to their homes like public health nurses."

- Nebraska Focus Group Respondent

Substance Abuse

Substance abuse is a serious problem among Nebraska girls and women, with an estimated 20,000 females age 12 and older dependent on alcohol or other drugs. (*Nebraska State Demand Needs Assessment*

Studies: Alcohol and Other Drugs, NHHSS, 2001). The 3 percent dependency rates for adolescent and adult females are lower than for males (4% age 12 to 18, 5% age 19 and older).

Alcohol accounts for most of the dependency. Among substance dependent females, 87 percent of adolescents and 70 percent of adults are alcohol dependent. Among substance dependent males, alcohol accounts for even more of the dependency (adolescents 91%, adults 78%). The consumption of alcohol is common across the state. Among adult women, 75 percent had consumed alcohol in the past year. One-fourth (25%) of girls age 12 to 18 drank alcohol in the past year. Regional differences in alcohol consumption and dependency are small.

Marijuana is the next most common dependency, but less than one percent of females are dependent on it. Statewide, 19 percent of women have ever used marijuana compared to 13 percent for girls. However, girls are more likely to have used marijuana in the past year (7% vs. 3%). Dependency rates are similar for the two age groups: 0.9% for girls and 0.8% for women.

Of the estimated 20,000 Nebraska women and girls in need of substance abuse treatment, only 5,363 were served in 2000 by public sector programs (Nebraska Division of Mental Health, Substance Abuse and Addiction Services contracted programs and Regional Centers, plus Medicaid). The 27 percent public program treatment rate for females is only slightly lower than for males

(30%). Undoubtedly, many receive treatment outside the public sector programs. However, there is clearly a large unmet need for services.

Women face similar obstacles to obtaining substance abuse treatment as they do for mental health services described earlier (e.g., cost, availability, child care and custody issues and time constraints). A particular problem is the fact that there is only one residential treatment program in the state for pregnant women and women with young children where mother and child can live together (at St. Monica's Behavioral Health Services for Women, Lincoln, Nebraska).

The Nebraska Coalition for Women's Treatment is working to address a number of substance abuse treatment issues for women. One of their roles is educating the public and professionals on women's treatment issues and advocating for gender competent treatment. They not only provide opportunity for collaboration among women's treatment programs, but also work with other agencies to address the co-occurrence of substance abuse, mental illness, and violence. They provide a trauma-screening tool and training for mental health, substance abuse, and domestic violence/sexual assault programs.



Domestic Violence & Sexual Assault

Domestic violence and sexual assault have a serious impact on many women and children in Nebraska each year. In 2000, the Nebraska Commission on Law Enforcement and Criminal Justice received 3,933 reports of domestic assault outside the city of

Omaha (a 3 percent increase over 1999) and 433 cases of forcible rape (a 5 percent increase over 1999). Of the 2,918 individuals arrested for domestic assault, 76 percent were male. Since the Omaha Police Department did not report domestic assault

statistics for 2000, the number of domestic assaults in the state as reported above is seriously deflated. The Nebraska Domestic Violence Sexual Assault Coalition reports serving 6,138 adult victims (primarily women) and 3,564 children and adolescents in FY 2000. That year the crisis line fielded 73,055 crisis calls. The Coalition, a statewide advocacy organization with a network of 22 programs, provides a variety of services including shelter, counseling, advocacy, transportation, financial assistance, telephone crisis line support, and prevention programs. It is important to note

that domestic violence and sexual assault are distinct forms of violence and different types of responses and programs are needed to address the problems.

The actual incidence of violence against women is much greater than the above statistics indicate because many women do not report the crimes. National studies estimate that 20 to 33 percent of all women will be physically assaulted by a partner or ex-partner during their lifetime. Domestic violence accounts for the symptoms of 22 to 35 percent of women who visit emergency rooms in the U.S.

Co-occurrence of Behavioral Health Problems with Domestic Violence & Sexual Assault

Women who are victims of domestic violence or sexual assault are more likely to have behavioral health problems (e.g., substance abuse, mental health disorders) than other women. A recent needs assessment study by the University of Nebraska at Omaha Department of Criminal Justice examined the relationship among treatment programs for domestic violence, sexual assault, and behavioral health in Nebraska. In spite of the impacts that domestic violence and sexual assault have on behavioral health of the victims, treatment programs are generally not designed to deal with these co-occurring problems. The report makes recommendations for coordinated efforts to improve the quality of these services.

"This is not just for women with kids, there are women who don't have families and health care is high (cost) and they might not have insurance. Would like a women's clinic that don't just see you for breast cancer, women's health in general not any specific disease."

*- Nebraska Focus Group
Respondent*

Health Care Needs & Barriers for Women with Disabilities

Women with disabilities experience many barriers that reduce the quality and accessibility of their health care. Although their numbers are small compared to the total population, they consume a significant share of the nation's health care services. Despite this, they are often underrepresented in health surveys and so data on their needs and significant health disparities are not

available. A recent study reported that 31 percent of the participating women with physical disabilities were refused care by a physician because of their disability (*National Study of Women with Physical Disabilities*, Center for Research on Women with Disabilities, Baylor College of Medicine, 1997). More women with physical disabilities reported chronic urinary tract infections, heart disease, depression, and osteoporosis at younger ages than the comparison group of women without disabilities.

The national study also found disparities for women with disabilities in several areas of gynecologic health care. Overall, women without disabilities receive mammograms 11 percent more often than women with disabilities. Younger women with disabilities have a significantly higher rate of hysterectomy



than able-bodied women. The reasons are primarily non-medical: for purposes of birth control or ease of managing menstruation. The causes of these disparities are often invisible barriers unique to this population – physicians denying services to women who cannot mount examination tables on their own or the lack of mammogram equipment capable of accommodating a woman in a wheelchair with limited muscle control. In addition, there is an attitudinal barrier, as some members of society, including some health care providers, perceive women with disabilities as asexual. Contributing to this problem is the fact that many women with disabilities are still receiving services from their original pediatricians.

Women with cognitive impairments including mental retardation in Nebraska report that some health care providers are reluctant to treat health problems including cancer aggressively. It is their perception that these physicians believe that the women are expendable members of our society and health care resources can be used better elsewhere. If the woman is non-verbal or has behavioral problems, the care issue is exacerbated.

Although there is little data on Nebraska women with disabilities, their health care needs must be addressed in any system to improve health care for all women in the state. Not only do these women experience health care barriers related to their disability, many of them also often face additional health care barriers related to being low-income.

Health Service Gaps for Low-Income Women

Nebraska women face a number of barriers to obtaining health care services, including high costs, long distances, lack of transportation, denial of services, lack of handicap access, limited English language skills, inconvenient hours of service, and lack of time. It is difficult to quantify these barriers in terms of the numbers of Nebraska women impacted by them. However, rough estimates can be made for some of these problems.

Low-income women face the double jeopardy of increased risk for health problems and fewer financial resources to access needed health services compared to those with higher incomes. Nebraska women who are Hispanic, Black or Native American are much more likely to be low-income than other women, although a large majority of women with incomes below 200 percent of the federal poverty level are White, non-Hispanic. Among the women of color, Native American women are most

likely to be low income, followed by Black women, and then Hispanic women.

This section of the report looks at the extent to which low-income women in Nebraska utilize certain public health service programs, and examines health coverage and service gaps by age and racial/ethnic group. In Nebraska, the principal programs that provide free or reduced-rate, direct health care services to low-income women are Medicaid, the Title X family planning program, and the Every Woman Matters (EWM) health screening program. The Title V/MCH Block Grant supports direct health care services on a limited basis (approximately 1,000 women per year), with a greater emphasis placed on enabling and population-based services. In addition, WIC provides nutrition services to pregnant and breast feeding women, and numerous programs provide health education services. This analysis is limited to the first three programs listed above, which provide direct health care services statewide.

Health Coverage & Utilization Rates

Table 5 presents the utilization rates for Medicaid, Title X, and EWM for low-income Nebraska women by age and estimates the numbers who are inadequately insured and not receiving program services. Overall the results show that one-quarter to one-third of low-income women age 18 to 64 are inadequately insured but are not receiving important public health services on an annual basis.

Although Medicaid is the public health program most utilized by low-income women, in every adult age group, it only

reaches a small portion of them. Whereas half of low-income girls age 12 to 17 are Medicaid eligible, the program reaches only one-fifth of adult women. This reflects the very restrictive adult eligibility criteria for the program.

One-fifth of all low-income women age 18 to 44 participate in the Title X program, as do 10 percent of girls age 12 to 17. Among women age 18 to 44 who are inadequately insured, the Title X utilization rate is 39 percent, assuming that all non-Medicaid clients are uninsured or underinsured.

Table 5. Health Coverage and Public Health Program Utilization Rates for Low-Income Nebraska Women by Age, 2002-2003

	Age Group	12 to 17	18 to 44	45 to 64	65 +
Nebraska Women 2003					
Estimated # below 200% Federal Poverty Level		27,314	123,766	43,559	73,964
Medicaid eligible		14,287	26,045	8,035	13,694
Estimated # un-/underinsured		6,052	55,695	19,602	11,095
Title X Family Planning Program Clients (<200%FPL)		2,679	24,382	990	0
Medicaid covered		529	2,917	118	0
Not Medicaid covered		2,150	21,465	872	0
Title X utilization rate		10%	20%	2%	0%
Every Woman Matters Program Client (<200% FPL)		0	2,416	4,606	688
EWM utilization rate		0%	2%	11%	1%
Health Coverage and Services for Women < 200% FPL:					
Medicaid Eligible		52%	21%	18%	23%
Adequately covered by private insurance/Medicare		26%	34%	37%	62%
Uninsured or Underinsured (non Medicaid):					
Title X client		8%	17%	2%	0%
EWM client		0%	2%	11%	1%
Not served by Title X or EWM		14%	26%	32%	14%
Total		100%	100%	100%	100%
Number low-income, inadequately insured women not receiving Title X or EWM services in 2002		1,045	31,814	14,124	8,187

Given the fact that Title X would provide subsidized services to any woman with an income less than 200 percent of the Federal poverty level, the utilization rate is fairly low.

The Every Woman Matters program serves 11 percent of low-income women age 45 to 64, including 23 percent of those who have no insurance or are underinsured. One reason for the low utilization rate is that some of the women who use the program only go in for screening every two or three years, thereby deflating the annual utilization rate. It should be noted that some women may be getting both Title X and EWM services – it was not possible to get an unduplicated count. Consequently, the estimate of those getting at least one service may be slightly inflated.

Only 14 percent of young women ages 12 to 17 are inadequately insured and not receiving Title X services. However, since those services are primarily for sexually active individuals, many of those without services might not need them. Neither Title X nor EWM are targeted to women age 65 and older, so it is to be expected that few older women are receiving these services. However, there is reason to be concerned about access to health services for seniors who do not have Medicare B or any “medigap” insurance, including prescription drug coverage.

Health Coverage & Utilization Rates for Low-Income Minority Women

Low-income Hispanic women have relatively high rates of utilization for both the Title X and EWM programs compared to other groups of low-income women. Fewer than 17 percent of those aged 18 to 64 are estimated to be inadequately insured and not receiving services. However, an unknown percent of them receive both Title X and EWM services, inflating the unduplicated estimate of those receiving any service. Unlike other groups, Hispanic women who are Medicaid eligible have a very high utilization rate for Title X (88% compared to 11% for all low-income women). Hispanic women age 65 and over are much more likely than low-income women overall to be Medicaid eligible, but have comparable rates at younger ages.

The relatively high utilization rates by Hispanic women age 18 and older for Title X and Every Woman Matters may occur because the programs are offered in settings that are more culturally and linguistically appropriate than are most private sector services.

Low-income Black women are half as likely to use Title X and EWM services as are low-income women overall. This might be due partly to relatively high Medicaid eligibility rates. Unlike Hispanic women, Black women with Medicaid coverage do not use the Title X program. Because of their high Medicaid eligibility the health service gap for low-income Black women in Nebraska is similar to the general population of low-income women.

Low-income Native American women in Nebraska are only one-third as likely to use Title X services, but just as likely to use EWM services as compared to the general population of low-income women. Since their Medicaid eligibility rates are similar to the general population for both the 18 to 44 and the 45 to 64 age groups, the reasons for this disparity may merit further investigation.

The availability of Indian Health Service programs to Native American women in Nebraska makes it difficult to calculate a health service gap for them. Most would be technically eligible for services, but information was not available on the extent to which they had adequate access to needed services.

Title X and Every Woman Matters programs are important sources of health care for many low-income Nebraska women. However, a substantial percentage of low-income women have a health service gap because they are inadequately insured and are not participating in either of these programs on an annual basis.

Overall, the results do not indicate a disproportionate gap in health services for low-income racial/ethnic minority women compared to low-income women overall. However, because women from racial/ethnic minority groups tend to have lower-incomes than White, non-Hispanic women, they are more likely to be at risk of inadequate health care coverage.

“When she go to the doctor before she met me they have an interpreter, but the person she asked to interpret for her cost her twenty dollars. The interpreter said-I’m providing transportation and interpreting and so you can donate anything you want. The seniors there only receive five hundred and something (dollars) per month; with the gas bills, the rent, and all the expenses, she can’t afford it. She go to the doctor twice a month and without an interpreter, the doctor ask her why she don’t bring an interpreter. Because I can’t afford an interpreter. He said next time you come back bring an interpreter. So she’s been back and forth about the expenses of providing for an interpreter on her own.”

- Nebraska Focus Group Respondent

Needs Assessment: Voices of Nebraska Women & Girls

The needs assessment for the Nebraska Women's Health Plan included a major effort to hear directly from Nebraska women on their health issues and needs and to obtain their ideas on ways to improve health services. This was done through the Nebraska Women's Health Survey, focus groups and a community forum on health issues for women of color, and the Nebraska Girls' Health Survey. The following is a summary of the results of those efforts. Copies of the full reports are available from the Nebraska Office of Women's Health.



Voices from the Nebraska Women's Health Survey

The Nebraska Women's Health Survey was designed to obtain information from women across the state on problems that they or other women might have in maintaining their own health or accessing quality health services, and to hear their ideas on ways for the state and its communities to address those problems. The survey was distributed through various state government and community organization networks in an attempt to reach a diverse group of women.

A total of 422 responses were received during February through April of 2003. The respondents were a good representation of the Nebraska population based on racial and ethnic group and on geographic distribution. They were more concentrated in the 35 to 64 age range than the general population of women. Although they represented a wide span of household income levels, incomes above \$50,000 were substantially over represented, while incomes less than \$25,000 were under represented.

1. Overall health status:

I am in very
poor health

(circle a number)
1...2...3...4...5...6

I am in excellent
health

The overall self-reported health status of the survey respondents is very good, with nearly two-thirds responding in the highest two categories of the six-point scale.

2. Thinking of health and wellness in very broad terms, what are your personal health and wellness goals?

Most women listed very concrete, behavioral health goals, with an overwhelming 80 percent listing some variation of “healthy diet, exercise, and weight control.” Nearly a third responded with some form of disease or injury prevention and control. Maintaining mental, emotional and/or spiritual health, including stress management, is a goal indicated by one-fifth of the respondents.

3. Some of the things that influence our health and wellness are up to us, and other things may be outside our direct control. What do you feel you are responsible for doing?

Most women indicated they are responsible for maintaining a healthy diet and exercising (87%). Disease prevention and control and maintaining mental health also were listed as their own responsibility by more than a quarter of the respondents, as was seeking regular and necessary health care.

4. If you are not doing the things you need to take care of your own health, why not?

More than a third of the respondents indicated they were doing what they needed to take care of their own health. For the 63 percent who were not doing so, the principal reason given was lack of time and the related issues of other priorities, taking care of others, and fatigue (60%).

5. How do you rate yourself in terms of taking care of your own health?

I take very poor
care of my health

(circle a number)
1...2...3...4...5...6

I take excellent
care of my health

Women reported they are doing a fairly good job of taking care of their own health, with half (49%) rating themselves in the highest two categories.

6. What problems, if any, do other women you know have taking care of their health?

Time and energy ranked as the primary reason given why other women didn't take better care of their health (52%). However, cost was listed as a much greater factor for other women (40%) than for themselves (7%). This likely is a reflection of the above average incomes of the respondents, and their awareness of the problems that lower-income women might have.

7. What things do you think can be done to encourage and support more women in your community to take better care of their own health?

The survey respondents offered a wealth of ideas on how to help women take better care of their own health. After each general category listed below, the percent of respondents is indicated, followed by some specific examples:



Outreach and education (75%)

- Provide encouragement through women's health groups, buddy systems, groups with similar needs, family health support groups.
- Remind and encourage women they need to take care of themselves first.
- Educate girls to have healthy habits at an early age.
- Provide easy access to health information resources.
- Provide practical tips on healthy eating and exercise for busy women.
- Offer workplace-based programs for health education.
- Provide emotional and mental health support.
- Develop and implement coordinated community strategic plans, including health providers, schools, businesses, and community leaders.
- Teach women how to take things off their plates, manage their time better, get men to do more.

Make healthy lifestyles more accessible and affordable (24%)

- Offer free or low-cost exercise programs and facilities.
- Make cheaper fresh foods and free or low-cost nutrition programs more available.
- Make healthy food choices more available in restaurants and vending machines.
- Offer workplace-based programs for exercise.
- Have more organized community events for exercise at school sports events, group walks, community walk-offs, etc.
- Provide more trails for walking and more facilities for exercising, especially in winter.

Make preventive health care more accessible and affordable (24%)

- Offer free or low-cost preventive services.
- Offer insurance coverage for preventive care.
- Offer insurance to part-time workers.
- Give paid time off for health appointments, and have more flexible work hours.
- Increase the number of community-based health services.
- Offer more culturally appropriate services and provide more translators where needed.
- Increase the hours and days that services are provided.
- Utilize mobile units to reach underserved rural areas.
- Increase the availability of family planning services.
- Offer childcare at health facilities.

8. Do you or other women you know ever have problems getting the health services you need? What are the problems?

Two-thirds of survey respondents indicated that they or other women they know have had problems getting health services. The following are the major types of problems:

- **Cost of health care (48%)**—no insurance and not eligible for low cost programs; costs of insurance, co-pays and deductibles; inadequate coverage of preventive care, pre-existing conditions, prescription drugs, dental, mental health, vision, fertility treatments and contraceptives; hard to get coverage for lesbian partners
- **Problems accessing services (26%)**—hard to get appointments; inconvenient hours and days of service; lack of time; lack of transportation; lack of child care; lack of services in rural areas; inadequate information; hard to obtain reproductive health services and prescriptions; no regular family health care provider; providers who won't take clients on Medicaid, Medicare or the uninsured; providers who turn away clients with mental health problems; difficulty getting needed services; and slow referrals with HMOs
- **Problems finding high quality, appropriate services (17%)**—finding providers who: listen, inspire trust, are respectful, are women-friendly, are female, who speak the same language, are culturally competent, who are lesbian-friendly

"I've been talked down to because I have Medicaid and treated like I was uneducated. I have left messages for people who would not return my calls. I have had to wait 40 minutes to an hour to be seen even though I had an appointment. I have scheduled appointments and then upon check-in was told that I didn't have an appointment."

*- Nebraska Women's Health Survey
Respondent*

9. Have you or other women you know ever been dissatisfied with the health services you have received? If so, what caused you to be unhappy or uncomfortable with the services?

Nearly three-fourths (72%) of the respondents reported that they or other women had ever been dissatisfied with a health service. The primary complaints were:

- **Doctor or staff attitudes (39%)**—disrespectful, not taking women seriously, not listening, inappropriate comments, preaching religious beliefs, talking down to low-income women, insensitive to lesbian issues, rigid in approaches to health issues
- **Doctor's poor communication (24%)**—not taking time, not giving enough information, giving poor or unclear explanations and instructions
- **Doctor or staff incompetence (11%)**—mistakes in diagnoses or prescriptions, misinformation, uninformed, test results not received, delays in care, inappropriate referrals
- **Problems with insurance and payments for service (6%)**—insurance refused to pay, high cost of service, upfront payments required
- **Poor administration of service (6%)**—scheduling mix-ups, long waits, poor communication among doctor, staff and other providers, records not forwarded
- **Culturally inappropriate, insensitive services (5%)**—providers insensitive to different cultures, lack of translation services, prejudice against minorities, lack of diversity among providers, prejudice against poor

10. What are some things you think can be done to help more women in your community get the health services they expect and need?

Responses generally pertained to empowering women to be better advocates for themselves, more affordable services, better access to services, and improved services:

Empower women to obtain better services (45%)

- Educate women about women's health issues, including health conferences and fairs.
- Train women on how to be assertive and better health care advocates for themselves, to ask the right questions, to change providers when needed.
- Inform women of the availability of services.
- Provide advocacy support for women who face serious health problems.



- Encourage women to advocate for legislation protecting women's health care rights.
- Encourage women to discuss and share information on health issues and services, including reproductive health and mental health; provide a place or website to share information about good services; develop support groups.
- Form a Latina support group for new immigrants with depression or other problems related to a new way of life.

More affordable health services (39%)

- Reduce the cost of insurance premiums and co-pays for those who can't afford it.
- Improve insurance coverage, encourage/require employers to cover more workers, improve processing of insurance claims.
- Offer universal health coverage.
- Make health services and prescriptions more affordable.
- Offer free preventive services, sliding-fee scales.
- Get rid of red tape on services for those in need, free screenings at health fairs.

"I stopped seeing my doctor for the last 10 years for regular check-ups and only see one now if I am sick or hurt. Even with having insurance through where my husband works, I cannot afford the deductibles and save my strength to fight the insurance company on medical care we have to have."

*- Nebraska Women's
Health Survey
Respondent*

Improve access to services (29%)

- Offer better hours and timely appointments.
- Provide better transportation and childcare facilities.
- Improve coordination and make appropriate referrals.
- Have mobile units, more physician assistants, and mid-level providers.
- Expand choices of services: more one-on-one visits, more rural services, monthly "visiting" specialists, more mental health services, and more information on available services.
- Improve access to family planning and reproductive health services; ensure reproductive health care is treated as basic health care, not subject to religious and personal bias.
- Coordinate efforts with community strategic planning and district health departments.

Improve health services (22%)

- Improve provider attitudes, listening skills, and respect for the dignity of all.
- Improve providers' understanding of women's health issues.
- Offer more women-oriented health services, e.g., more women-only clinics, more women doctors, more women-oriented health education, more attention to women without children, more dollars for prevention and research on women.
- Train physicians about gay/lesbian/transsexual/transgender health issues; offer more lesbian-friendly services: provide places to share information about lesbian-friendly providers.
- Establish more community clinics that provide culturally competent services to diverse population groups and offer more translation services.
- Improve health procedures to be less invasive, less unpleasant.
- Encourage doctors to provide health information packets and provide written instructions and explanations.
- Improve staff education, e.g., give physician assistants more annual updates and trainings as done for emergency medical technician (EMT) providers.
- Improve doctors' self-monitoring, make providers accountable to patients, screen providers more closely, encourage doctors to have lower caseloads.
- Provide follow-up care as needed after screenings, get faster turn-around on tests.

Voices of Women of Color

Racial/ethnic minority women have unique health care needs, diverse perspectives, and valuable views to contribute on health issues. Yet, they traditionally have been absent during important discussions and decision-making about health care delivery. The Nebraska Department of Health and Human Services Offices of Women's Health, Family Health, and Minority Health and the Nebraska Minority Public Health Association (NeMPHA) co-sponsored a study on health issues for women of color in Nebraska to provide needed information for the development of the Nebraska Women's Health Plan.

NeMPHA used two methods to gather information: a series of six focus group discussions in July 2003 and a community health forum in August 2003. The following is a summary of the outcomes of those meetings.



Focus Groups

A total of 56 women participated in six focus groups, each of which lasted approximately two hours. One group consisted of individuals from the Black/African American population, one group from the Vietnamese population, two groups from the Native American population, and two groups from the Latina population. Two focus groups were

conducted each in Omaha, Lincoln, and Scottsbluff, Nebraska. Two groups were held in Spanish, one group in Vietnamese, and three in English. Most participants had a household income of \$10,000 or less.

The same facilitator led each focus group, asking participants questions related to the following topics:

- Their views on what are the most important health issues for women in their communities
- Their awareness of any barriers faced by them or other women they know to receiving health care or adopting healthy behaviors
- Their experiences as health consumers in Nebraska
- Their views on what policy makers, insurance plan administrators, public health officials, or other health care providers can do to better meet their needs or the needs of other women they know

Unless an exception is indicated, the major findings in this report reflect consistent participant views across all six groups.

Health Care Access Issues

- Lack of medical insurance, lack of prescription coverage, lack of money, and lack of knowledge of resources are major barriers to accessing health care. Participants suggested establishing payment plans at clinics, hospitals, and specialty clinics. They want affordable health care coverage.
- For the uninsured, it was recommended that medical facilities allow payment plans, establish sliding scale fees, and make referrals to low-cost medical care and specialty clinics.
- Participants requested affordable insurance with adequate coverage. They are willing to make partial payments on premiums of employer-based coverage in order to obtain medical insurance coverage for self and family.
- Participants stated that at times they were unable to pay for high-cost prescriptions. Those with insurance who pay their premiums bi-weekly have a deductible to meet and the insurance doesn't cover the cost of medication. Participants recommended indigent prescription programs.
- Obtaining Medicaid insurance is difficult. The Nebraska Medicaid application is many pages in length and the documents needed by the applicant attempting to apply, along with income verification, is reported to be burdensome.
- Many physicians, dentists, and optometrists do not accept Medicaid or they do not accept new Medicaid patients.
- Participants said they had to wait an average of three weeks to obtain an open medical appointment for acute health problems, and once they arrived for the appointment they had a long wait in the waiting room. They noted other patients with health insurance or White patients went back to the examining room sooner. Racism was cited.
- Lack of access to reproductive health care; and sexually transmitted disease (STD) diagnosis and treatment, including cervical cancer and breast cancer screening and treatment were mentioned across the six focus groups.
- Other health issues of concern are cancer, diabetes, heart disease, alcohol/drug addiction, depression, and lack of transportation. Participants reported that it is difficult to obtain transportation to medical appointments. Scottsbluff Native American residents go to Pine Ridge Indian Health Service in South Dakota, which is a two-hour van ride one direction. Native Americans from Lincoln go to Winnebago Public Health Services in Winnebago, Nebraska and the Carl T. Curtis Health Clinic in Macy, Nebraska, which are one-and-a-half-hour trips each way. Scottsbluff and Gering do not have a public transit system.

"When she goes to get her eye exam, because of the language (barrier), he asked her to look up, and when she look up-not the way he wanted her to- he yelled at her and made her scared. After you feel scared already after the doctor yell at you. Ever since then she is afraid to go back to him."

- Nebraska Focus Group Respondent

Culturally & Linguistically Appropriate Services Issues

- Language barriers pose a problem to accessing health care: the insufficient engagement of positive health care provider-patient interactions results in less than high quality outcomes. Health information is not available or accessible in Spanish and Vietnamese. Health care providers are not from participants' racial/ethnic backgrounds, nor are they female.
- Some non-English speaking participants with insufficient incomes reported they are required to pay for language services from an agency whose task is to provide transportation and language services.
- Qualified, trained medical interpreters/translators was identified as an immense need.
- Some participants felt they were inappropriately touched during examination. Some participants expressed their desire to have female health care providers.
- Support is needed in the form of culturally and linguistically similar individuals who are health advocates, public health nurses, case managers, and Promotoras (community health educators/advocates in Latina communities). Participants recommended obtaining family support and community support from churches, community based organizations, and cultural centers. Addiction support groups are needed.
- Participants reported they felt respected when they were greeted upon arrival, when the employees of the medical facility knew them and called them by first name, when privacy was provided to them, and when they were informed of their patient rights. They gave accounts of kindness and gentleness shown to them: when the health care provider was soft spoken, shook their hand and asked how they're doing. A smile went a long way to show deserved respect.
- Participants were in accord when they demanded that they not be put into categories with White women, and want their racial/ethnic health issues to be looked at separately.



Health Promotion & Education Issues

- Barriers to receiving information about and/or adopting healthy behaviors include lack of access to consistent health care providers, lack of health education opportunities, lack of relevant materials in various languages, and lack of support from the community.
- Participants stated that habits are hard to break, and that behavior changes do not always align easily with their lifestyles. They recommended community support from cultural centers and home visits from public health nurses, case managers, and Promotoras. They requested assistance with setting and maintaining goals.
- There is a need for access to health promotion programs such as smoking cessation, diabetes education, and disease management. Access would include transportation,

childcare or a child friendly atmosphere. Health education materials need to be culturally and linguistically appropriate. Information and support on goal setting and incentives need to be integrated throughout the programs.

- Participants affirmed that they received their health information from a variety of sources: newspaper, peers, family, doctor, news, mail, pamphlets, magazines, television, fliers, Native American outreach, friends, newsletters, library, the Internet, and community based organizations and health clinics.
- Participants prefer to receive their health information from local churches, community-based organizations, cultural centers, KZUM radio during culturally specific programs, during home visits, through presentations, and via Promotoras. It is essential that all information be culturally and linguistically appropriate.

“A lady from the church went for a mammogram and she tried to tell them they were hurting her, and instead of loosening up-they mushed it (breast) a little harder. They treat Latina woman with little less respect and privacy. ... Nobody explains that it is suppose to hurt; now she (her friend) won't go, word of mouth gets around.”

- Nebraska Focus Group Respondent

“For a while it was so hard to get them [my kids] to see the doctor because they're always full. It seems like it should be for Indian kids but I've been taking my kids to the emergency room because their (clinic) is so full. And they want you to call by nine o'clock in the morning and by that time they are still full.”

- Nebraska Focus Group Respondent

Community Health Forum

On August 7, 2003, the Nebraska Minority Public Health Association held a community forum at the OPS Teacher and Administrative Center in Omaha. Over 40 women of various racial and ethnic groups and socioeconomic levels attended the forum.

Mrs. Berry, an African American consumer, was invited to open the forum discussion by sharing her health needs and her recent health care experiences both in Omaha and in Michigan with women in the audience. Dr. Lavedan, a family practice physician/internist and a woman of Filipino descent; and Ms. Stancil, an African American mental health therapist; discussed

women's health issues from a provider perspective related to prevention, early detection, diagnosis, treatment, quality of life, and health across the lifespan. Following each presentation there was a question and answer period. A high percentage of women discussed the importance of prayer and spirituality in overcoming personal health issues.

After the presentations, women formed four groups of approximately ten each. Recorders and facilitators were assigned to each group to lead a discussion of the following questions and to bring back responses to the larger group:

- What are the personal and system barriers that prevent women of color in Nebraska from achieving optimum health?
- What are your recommendations to remove the personal and system barriers that prevent women of color in Nebraska from achieving optimum health?

Personal Barriers

- Lack of knowledge
- Lack of money/insurance
- Lack of understanding health issues
- Lack of trust
- Fear of what results will show
- Lack of transportation
- Language barriers
- Time factors
- Lack of child care
- Lack of personal support systems
- Lack of energy
- Access
- Personal habits: unhealthy eating habits, lack of exercise
- Not being in touch with one's body
- Tradition – only go to the doctor if individual is forced to

"I went to _____ and I was in the emergency room and I broke out in hives. And this young doctor (I didn't know he was in training at the time), he said, 'Are you sure you're from north Omaha?' I said, 'Excuse me'. He said, 'You are very articulate. That means...' I said, 'I know what it means and I want another doctor in here.'"

- Nebraska Focus Group Respondent

System Barriers

- Bureaucracy
- HMO restrictions
- Accessibility to health care system
- Availability of health care facilities
- Societal expectations
- Insurance: cost, availability, knowledge
- State and Federal government: Welfare to Work – high deductibles and co-pays for Welfare to Work employees
- Fear because of previous experiences
- Lack of cultural competency

Recommendations for removing personal barriers



- Increase health education
- Develop support systems
- Provide more public funding
- Provide network of resources for services needed
- Increase family income
- Offer flexible hours for health providers
- Increase community outreach
- Prioritize self care

Recommendations for removing system barriers

- Improve transportation options
- Offer childcare in the clinics
- Campaign to the senators and congressmen and representatives
- Present more pediatric health issues
- Increase provider cultural competency skills
- Improve output of information on affordable medical coverage
- Provide community health forums/education
- Implement health reforms
- Increase the number of interpreters
- Increase the diversity of providers
- Increase provider cultural competency/training

Voices from the Nebraska Girls' Health Survey

The Nebraska Girls' Health Survey obtained information from adolescent girls across the state on problems girls might have in terms of being healthy and feeling good, their sources of health information, and their ideas on ways to help girls avoid health problems. The survey was distributed in May and June 2003 to girls through the Girl Scouts (Great Plains and Goldenrod Councils), Planned Parenthood in Omaha, Campfire in Omaha, and Panhandle Community Services in Gering. Return envelopes to NHHSS were included so that the girls could complete the survey and mail it in anonymously.



Altogether 105 completed surveys were returned: 25 from the Omaha area, 14 from the central part of the state, and 66 from the Gering/Scottsbluff area. Girls ranged in age from 11 to 19, with a median age of 15.

Three-fourths of the girls were White, non-Hispanic and nearly one-fifth were Hispanic. Black girls were underrepresented among the respondents. A sizeable proportion of the girls came from lower-income families (40%) based on those for whom lunch price status was available.

1. What do you think are the differences between healthy and unhealthy girls your age? *Under the headings below, list your ideas of what each type of girl is like or how she behaves.*

Most of the girls responded with paired opposites, e.g., “eats healthy” – “eats unhealthy.” The examples have been edited to present the “healthy” version of the characteristic or behavior and are summarized below in terms of general categories of response, the percent of girls giving that response, and examples of each. Because girls gave multiple responses, the percents add up to more than 100.

- **Fitness and energy (46%)**—exercises, plays sports, plays outdoors, gets enough sleep, not tired all the time, doesn't watch T.V. all the time, doesn't do too much exercise, not overly energetic, is peppy
- **Attitude and emotional state (40%)**—cares about self, happy, has limits, has faith in self, smiles, cares about grades, positive attitude, not depressed, enthusiastic, knows what's important, emotionally stable, is successful in school
- **Nutrition (36%)**—eats healthy, avoids carbonated drinks, eats fruits and veggies, drinks lots of water, avoids junk food, drinks milk, has good appetite
- **Relationships (28%)**—friends, helps others, respectful, has fun, active in school and community, not mean, doesn't fight, talks to parent/guardian, not lonely, good values
- **Drugs, alcohol, smoking (26%)**—doesn't smoke, doesn't do drugs, doesn't party
- **Personal hygiene (22%)**—takes a bath every day, clean teeth, clean hair, no body odor

- **Sex (22%)**—has protected sex, not promiscuous, waits as long as possible, does not have sex, doesn't have multiple sex partners, is in a good relationship first
- **Weight, body image (21%)**—"normal" weight, not bony, doesn't have eating disorder, not fat—not skinny, positive body image
- **Health status, health care (17%)**—doesn't get sick very often, doesn't have asthma or diabetes, doesn't get headaches, goes to doctor for "feminine" exam
- **Appearance (11%)**—appropriate dress; doesn't slump around; looks healthy; doesn't wear ratty, dirty-looking clothes; doesn't have dark circles under eyes; is pretty

The girls who responded to this survey clearly have received a number of appropriate health messages. Weight issues did not come up as often as one might expect (21 percent of girls). Perhaps that was because the question concerned health and not looks. Issues of emotional and interpersonal development for adolescents are very prominent here, representing two of the top four categories mentioned.

2. How do you rate your own health on a scale of 1 to 6?

The girls reported their health to be fairly good, with 55 percent responding in the top two categories and only 11 percent responding on the lower half of the scale.

3. How often do you feel good? (range is from almost all the time to almost never)

The majority (53%) of girls reported feeling good almost all of the time. Only 7 percent said they feel good only once in a while or almost never.

4. How do you learn about ways to stay healthy and feel good? For each item in the list, put a check to indicate whether it is never, rarely, sometimes or often a source of information about ways to stay healthy and feel good.



Parental figures and family health professionals were their primary sources of health information, with more than three-fourths using each source sometimes or often (84% and 83%). Friends or schoolmates, teachers or counselors, books or magazines, and television or radio were a source for the majority of girls (66%, 64%, 61%, and 56% respectively). School nurses, girls' or youth group leaders, religious group leaders, and the Internet were less likely to be a source of health information (46%, 40%, 40%, and 36% respectively).

5. Are there some health topics you would like to know more about, but don't know whom to ask or where to find out? If Yes, what are the topics?

Only 10 percent of the girls indicated that they had health questions they did not know whom to ask or where to find the answer. The following topics were listed:

- **STDs:** what happens if you are diagnosed with an STD and you don't treat it
- **Pregnancy and sex:** whether you're ready or not to lose your virginity, facts about birth control, information on puberty
- **Weight and fitness:** being healthier and losing weight, what exercises to do, how much of what foods to eat
- **Diseases:** pneumonia, flu, hepatitis, HIV, heart problems, diabetes, Marfan syndrome

6. What do you think are some potential problems for girls your age that could hurt their health or make them feel bad? List at least five things if you can.

The majority of girls (58%) indicated that peer pressure and harassment, including from boyfriends, was a problem for girls. Poor mental attitude, family problems, and the consequences of sex were the second most mentioned problems.

- **Pressure or harassment from peers or boyfriends (58%)**—peer pressure, bad company, teasing, rumors, abusive relationships, boys' expectations, harassment, bullying, rejection, discrimination for being different
- **Poor mental health or attitude (31%)**—poor self-esteem, stress, false image of "healthy" body, laziness, depression, trying to live up to other's expectations, poor body image
- **Family problems (31%)**—bad home life, parents divorcing, poverty, not able to talk to parents, losing a family member, physical or sexual abuse, parent in prison, fighting with siblings, poor guidance
- **Consequences of sexual activity (29%)**—getting pregnant, STDs, parenting, having sex before you are ready
- **Media influence and societal pressures (18%)**—television, movies, society pressure to be thin, magazines, skinny models, society's standards
- **School and community problems (14%)**—availability of drugs and alcohol, inadequate health education, male teachers, too many activities, inadequate sex education, grades, jobs
- **Non-family violence (6%)**—fighting, rape

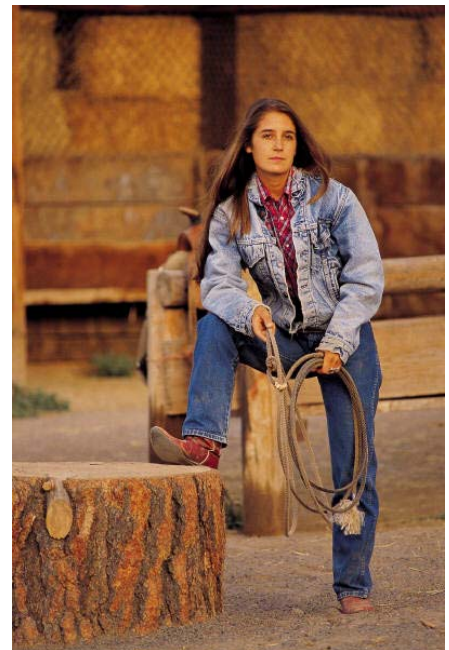


7. What do you think are the best things that can be done to help girls avoid the problems you listed above? List at least three things if you can.

The girls gave two general categories of response: messages to give to girls, and suggestions about what the adult community can do to help girls.

Messages to girls:

- Have better self-esteem. Know that you are fine the way you are. Notice the “good” instead of the “not good” things about yourself. Learn to respect your body. If people say you are fat, don’t listen. Avoid listening to the cruel criticism of your judging peers.
- Have good friends. Follow your beliefs and not the crowd. Don’t try to impress other people or live for someone else. It’s impossible to meet the expectations of others—they will never be satisfied—you have only yours to live up to. Don’t do anything you don’t want to do. Try not to read magazines targeted for teenagers. Learn about God.
- Everybody keep their mouth shut about their opinions. Be kind to other girls and not rude. Say nothing about their weight or how they look. Always try to complement others. Do not tease. Don’t call names. Don’t hit. Make friends who are encouraging and uplifting instead of making degrading comments.
- Talk to someone who will listen. Talk to your drug counselor. Get help. Get support from your parents. Never give up—talk to a counselor or someone who can help. See the doctor. See the counselor. Get positive reinforcement.
- Eat healthy and regularly. Don’t eat as much. Eat vegetables and fruit. Eat. Get information on how to eat right. Ask what is in your food. Take your medicine. Take a daily bath or shower. Use deodorant. Go to sleep a couple of hours before you usually do. Exercise to maintain good weight.
- Tell your boyfriend how you feel about sex. Don’t have sex. Say NO! No means no. Know the consequences. Be more informed. Use condoms. Don’t have many partners. If sexually active, use birth control. Have safe sex. Save sex for marriage.
- Stay away from drugs, alcohol and other negative situations and influences. Don’t hang out with people who do drugs. Don’t get mixed up in the wrong crowd. Don’t fall into the traps of temptation. Ask people around you not to smoke.
- Write, relax, run. Be extremely active in clubs, etc. Work more in school. Live life to the fullest. Find other things to do rather than party. Be in sports. Find a better focus—keep your mind and time on something that interests you—get into something positive. Get a job. Make good decisions. Set good goals and stay focused on them!



Strategies for adults:

- Have a supportive community of family and friends. Have a more accepting society. Encourage strong relationships with persons their age of both sexes (not boyfriend-type). Tell them nobody's perfect and everybody is handicapped in some way or another. Talk to your girls and listen more. Tell them they look good. Tell them you will always be there. Encourage girls to have self-esteem. Good parenting. Tell them it's not what's on the outside but the inside that counts. Improve their home lives. Promote relationships with unrelated adults of both sexes.
- Teach them how to handle peer pressure. Help girls get good habits. Provide education from home and school. Provide nutritional facts. Keep health pamphlets and books available. Be good role models. Put more ads on T.V. to show they don't have to follow standards that society sets. Get involved in the community to pass information on.
- Tell them what happens if they have sex. Tell them to use protection and how to use it. Make them realize how stupid drugs are. Inform them what bulimia, anorexia, drugs and alcohol do to their bodies. Show how models are anorexic and imperfect.
- Provide people for girls to talk to. Provide a place for them to come and talk to people. Make the issue seem less important than it is to lessen the tension/hostility surrounding the issues--opening it up for conversation. Discuss health and premarital issues with religious leaders in the community. Have classes to talk and discuss these problems and find solutions.
- Provide treatment centers for girls. Have help available in schools. Have counselors help girls with their attitudes. Give them support or try to find help for them.
- Offer group sports. Provide activities for older girls on Friday and Saturday nights. Offer after school activities, summer programs, and job internships. Offer alternatives for competitive sports. Have a later start for school. Encourage healthy foods in schools (more choices).

It's clear from the girls' responses that many of them recognize the dangers of drugs, alcohol and sex. However, their overriding concerns are for emotional support, not only from the adults in their lives, but also from each other. Their insights are encouraging and probably reflect the benefits they have gained from participating in the programs through which the survey reached them. The strategies they suggest for adults are mostly common sense ideas – their usefulness lies in the fact that girls are saying these are important to them. The results of this survey should reinforce our commitment to provide girls with strong emotional support, effective health education, and an environment that encourages healthy behaviors.



Guiding Principles & Goals



The Nebraska Women's Health Plan is intended to be a dynamic tool to help achieve realistic objectives for addressing the priority health needs of women in Nebraska. The priority goals, issues, strategic objectives, and specific action steps will change over time to reflect substantial progress in some areas, the availability of resources, and the emergence of new health issues. The New Dimensions Partnership identified a set of principles to guide the development and implementation of the statewide plan. These guiding principles

are beliefs, concepts, and statements that provide a strong and stable foundation that can support a diverse and evolving array of goals and objectives.

Guiding Principles

- Women traditionally are the gatekeepers to family and community health – by improving women's health we improve the health of all.
- The elimination of health disparities across population groups is imbedded in all the goals and strategic objectives for improving women's health.
- 'Women' refers to females across a wide age range from pre-adolescence to very old age.
- 'Health care providers' refers to a broad and diverse array of health professionals, not just physicians.
- This plan encompasses solutions that affect all individuals, systems, and environments that impact women's health.
- Men need to be engaged as part of the solution to the issues surrounding women's health.
- The benefits of the plan are designed to reach across the entire state to address every resident's issues around women's health.
- There is a commitment to ensure that a certain level or set of services are available to all women in Nebraska regardless of where they reside.
- This plan reflects the belief that statewide efforts and actions as well as community efforts and actions are essential for achieving an improvement in women's health.
- Each individual organization in the New Dimensions of Health for Nebraska Women Partnership is committed to contributing what it can in the way of resources – this is a statewide plan, not a plan just for state government.
- This plan is intended to empower women and give them the tools they need to lead healthy lives – it does not 'impose' solutions on women.

"If my husband goes in with a complaint he is heard, but if I go with a complaint it seems it is often in my head. I don't know how to change this viewpoint of women. I am a well educated woman and I still feel this when I try to access services, so I can imagine how less educated women are perceived!"
- Nebraska Women's Health Survey Respondent

- It is intended that organizations and women review this plan and ‘make it their own’ based on their own needs, unique circumstances, and capacities.
- The ideal outcome for this plan is to prevent health problems and disease – but when prevention is not achieved, to ensure the availability of systems and services to adequately address health problems and disease.
- We are committed to the freedom to discuss and deal with all health issues and solutions – there are no issues that should not be discussed, regardless of topic or beliefs.

Priority Goals

“Physicians don’t take women seriously. They forget our needs are different, Need more time to discuss options with health care providers. We need more women’s health centers instead of doctor’s office where everyone is treated the same.”

*- Nebraska Women’s Health Survey
Respondent*

The New Dimensions of Health for Nebraska Women Partnership identified five of the Nebraska 2010 Health Goals and Objectives as priorities for the women’s health plan. The Nebraska goals were established in response to Healthy People 2010, an initiative for health promotion and disease prevention sponsored by the U.S. Department of Health and Human Services. The priority goals for this plan are listed below, accompanied by the Healthy People 2010 goal statement:

- **Access to Quality Health Care**
Improve access to comprehensive, culturally and linguistically appropriate high-quality health care services.
- **Education and Community-Based Programs**
Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life.
- **Mental Health and Mental Disorders**
Improve mental health and ensure access to appropriate, quality mental health services.
- **Nutrition and Overweight**
Promote health and reduce chronic disease associated with diet and weight.
- **Physical Activity and Fitness**
Improve health, fitness, and quality of life for all through daily physical activity.

The selected goals represent the participants’ priorities based on the needs assessment conducted for this initiative, their personal knowledge and experiences, and realistic opportunities to have an impact. The interconnection of health issues ensures that efforts to achieve a given goal are likely to impact other goals as well. As progress in certain areas and new issues arise, priorities are likely to shift.

Women's Health Program Challenges for State Government



A significant component of the Nebraska Women's Health Plan is an internal state government strategy for better integration and enhancement of state supported programs and services that impact women's health. This strategy was developed at the internal strategic planning meeting in May of 2003, which was attended by representatives of approximately 40 programs in NHHSS that relate to women's health.

Program Challenges

The participants in the internal planning session identified a number of challenges that impact the delivery of women's health-related programs and services:

Operations

- Data is not utilized as well as it could be to direct policy and program decision-making.
- Many program staff members are reticent to discuss difficult crosscutting issues such as racism in health care and reproductive health issues, including abortion and total abstinence.
- Workforce development is a critical need for most programs, including:
 - Staff recruitment
 - Staff retention (both in and out of the state system)
 - Staff quality
 - Staff training
 - Turnover issues such as orientation to other programs, relationship building, etc.
- There is a need for cross-education and cross-training among state programs and services as well as health care providers.
- Categorical programs often serve multiple masters, e.g., state and federal agencies.
- It is often a challenge – especially in state government – to think and act “outside the box.”
- Many programs are in need of more support services.



- Many programs are in a state of change and thus in need of change management skills by managers and staff.
- Because these programs are in state government, the time involved in administrative bureaucracy for staff can be very time consuming.

Funding

- Funding is 'maxed' out in most programs.
- In light of so many funding cuts, there is a growing and constant worry about the continued ability to serve those in need of these critical services.

Target Populations



- Many programs are struggling with interpreter and/or translator issues.
- Racial/ethnic minority representation and ongoing minority participation in program recruitment and service delivery is a challenge.
- It is often a challenge to engage consumers in programs and successfully impact their behaviors and their ability to follow health care advice.
- If a person is in the target population for multiple programs, we can easily "over-target" individuals and inundate them with information in a short period, for example, new mothers.
- Many programs need to address the attitudinal problem of caregivers and health care providers towards vulnerable populations and women in general.

Access to Programs & Services

- There is an increasing demand and need for women's health programs from the public.
- Navigating multiple access points for programs or services can be confusing to the target population as well as the health care provider.

Integrating Women's Health Programs & Services

The principle focus of the internal strategic planning process was to identify opportunities for enhancing services and programs through better integration. This includes:

- Seeking opportunities to assist each other to improve the impact of all programs
- Thinking collectively and working differently to impact chronic disease in new ways

The anticipated benefits of increased integration include:

- A greater overall impact on chronic disease rates – a healthier public
- Integrated mechanisms to systematically identify problems, gaps, and shared opportunities
- Increased opportunities to secure resources
- More effective and efficient daily work
- Shared data
- Clearer roles and responsibilities
- Joint problem solving around tough issues
- Learning from each other and with each other
- Coordinated efforts to reach the same populations and organizations

A number of internal state government short-term and longer-term strategies were identified for improving integration. These strategies are included in the following discussion of priority health issues under the specific topics to which they most closely relate, namely health system isolation, access to appropriate services, and funding.

“Doctors are so busy that they don’t take the time to explain a health problem to a lay person in lay person’s terms. I have had diagnoses and not had them explained and what to do to solve the problem...like what diet to consume or stay away from.”

- Nebraska Women’s Health Survey Respondent

Priority Health Issues & Strategies

The New Dimensions Partnership identified a number of interconnected issues that get in the way of reaching the goals for Nebraska women's health listed above. Five of those issues were selected as priorities for the plan to address. The priority issues have been defined broadly enough that they encompass the others that were identified. Strategic planning within internal NHHSS programs identified similar issues.



These health issues reflect the concerns and resources of those participating in the planning process. As the New Dimensions Partnership grows and as other stakeholders review the plan, the priority issues might expand or shift somewhat in future planning periods. The current plan is focused on addressing the following issues:

- Isolation within the overall health services system
- Inadequate access to culturally and linguistically appropriate health services
- Lack of mutual support systems for women
- Stigma, fear, and taboos around certain health issues
- Inadequate funding

The Partnership members developed a number of strategies to address each of the priority issues. These strategies are described below, along with strategies identified in the internal NHHSS strategic planning process.

Isolation within the Overall Health Services System

Health services in Nebraska generally suffer from “systemic isolation.” Instead of being comprehensive and integrated, services are fragmented and segregated. Isolation occurs on a number of planes including, among others, geographic area, lack of understanding of prevention, type of disease or problem, program boundaries, funding category or source, and type of provider.

Isolation is a major obstacle to each of this plan's priority goals for women's health. It is a major contributor to the following problems:

- It is difficult to connect “best practices” across various women's health services.
- Referrals operate within narrowly defined networks.
- Many providers and programs are unaware of or are disinterested in the broad array of available health care and promotion services, including those that are non-



- medical, community-based, faith-based, or non-traditional.
- It is difficult for women to know about and access the available services they might need.

Although some innovative broad-based connections exist, the system needs many more in order to become truly comprehensive and integrated.

Strategies to Reduce Isolation

The New Dimensions Partnership identified the following strategies, the first three of which were selected as priorities for the 2004-05 planning period and are discussed more fully below:

- **Redefine local/regional health departments as Community Health Departments.**
- **Develop partnerships among service providers.**
- **Increase awareness of community resources for women's health needs.**
- Educate providers that substance abuse, mental health, and violence against women are health issues for women.
- Enhance the referral network process.
- Provide more prevention services and health education for adolescent females.
- Increase accountability for coordinated services through funding requirements.
- Promote culturally and linguistically appropriate services to actively integrate women from all racial/ethnic minority groups.

Redefine local/regional health departments as Community Health Departments

A "Community Health Department" is one which:

- Covers the broad range of community health issues
- Is engaged with the full array of health providers in the community
- Provides services for all members of the community
- Takes a more holistic and less categorical approach to health for the whole family

A Community Health Department can help ensure that health issues are adequately addressed by assessing the community's health needs with local data, evaluating the community's capacity to meet those needs, and identifying additional resources to assist in these efforts.

"In my personal opinion, some of the barriers I have found is that we don't go to a doctor because we are ashamed or are shy, like when we get Pap smears. Also the language is a barrier, and lack of compassion."

- Nebraska Focus Group Respondent

Develop partnerships among health service providers

Partnerships are proposed as a way to increase connections among health providers and organizations that serve women. The connections would bridge categorical mindsets by identifying common beliefs and values from a variety of perspectives.

Partnerships not only would be developed across provider categories within the medical field (e.g., family practice physicians, gynecologists, rheumatologists, dentists, psychiatrists), but also would connect traditional medical providers with health service providers in non-medical professions (e.g., victims advocates, mental health counselors) and non-traditional medical professions (e.g., massage therapist, acupuncturist, promotoras, curanderas). These partnerships also would connect organizations that serve women (e.g., prisons, shelters) with a broad array of health providers.

The benefits of health service partnerships include:

- Decreased levels of competition, feelings of threat, and unnecessary overlap
- Increased willingness to share and connect resources
- Increased ability and opportunity to connect categorical plans, programs, and resources at the state and community levels
- Increased opportunity to pool resources for greater impact
- Decreased administrative overheads (e.g., reporting requirements)

Increase awareness of community resources for women's health needs

Health providers and consumers alike need more information about the resources that are available for women's health needs. Providers need to know what local resources exist and how to connect to them. In particular, they need increased awareness of who can provide screenings and other services. Women consumers also need to know what local resources exist and how to connect to them, and have a right to expect the integration of coordinated services.

Increased awareness on the part of providers and consumers would benefit the community by:

- Helping providers do a better job
- Empowering women to be better advocates for their own health
- Enabling women to communicate more effectively with providers and service organizations
- Increasing the types and quality of referrals
- Increasing trust and cultural sensitivity between providers and women consumers



NHHSS Short-term strategies: The internal strategic planning team for women's health identified the following short-term strategies that pertain to reducing isolation.

- Identify mechanisms for inter-agency discussion of key issues and to disseminate key information, including policy information.
- Develop and monitor an electronic bulletin board to post what all women's health related/interested programs are doing, and what needs these programs and services have.
- Develop a mechanism for joint community assessments, creating a "library" of assessments that can be accessed by all programs and services.
- Convene program staff with similar programmatic interests in order to identify common needs and staff development.
- Review the newsletters and informational brochures that programs currently develop to assess for overlap, gaps, and opportunities for common message development. Identify opportunities for communicating more effectively.
- Create a phone tree, listserv, or other communication mechanism for all women's health related programs and services.

NHHSS Longer-term strategies: The internal strategic planning team for women's health identified the following longer-term strategies that pertain to reducing isolation.



- Develop a 3-year integrated marketing plan with shared messages, e.g. on the linkages between diabetes, exercise, and nutrition.
 - Develop comprehensive women's health state and local assessments that help drive both state and local agendas and efforts. These efforts should be connected to short-term plans.
 - Develop a strategic plan that is focused at the program level with the philosophy of "bottom up rather than top down."
 - Analyze outcomes from women's health program efforts around the state. This effort could include a "GIS" person and focus on identifying best practices, distribution of services and programs, and client utilization data and patterns.
 - Identify and eliminate duplication in data, then package and disseminate the data to drive health policy.
-
- Identify needs for workforce trainings on new emerging issues such as smallpox—external agencies in the state have the capacity to do this.
 - Create mechanisms for better communication among agencies.

- Look for ways to integrate and partner more fully with economic programs – both health and other economic development programs.
- Share information between tribal data sources (Indian Health Service) and state government for a more complete women’s health picture.

Inadequate Access to Culturally & Linguistically Appropriate Health Services

The current health system tends to “lock out” or limit access for certain groups because they cannot readily obtain the appropriate services they need. Access to services that are *appropriate* can be limited by language, race, ethnicity, culture, gender, age, sexual orientation, and disability status. Barriers resulting from such factors as geography, economic status, employment hours, health coverage, transportation needs, childcare needs, and disability status can limit access to services in general.

“Many low income women do not have health insurance and so little problems become big problems. One woman on Medicaid was told her health problems were due to obesity. Finally, she was diagnosed with MS after asking her doctor for help for close to a decade. Because it went undetected for so long, she is now in a nursing home at age 44.”

- Nebraska Women’s Health Survey Respondent

Health disparities are a likely risk for those who have limited access to the health care system. Large disparities are well documented for members of racial/ethnic minority groups as well as for individuals living in poverty. The current system lacks an adequate level of targeted and appropriate outreach to underserved population groups and geographic areas.

Most non-metropolitan counties in Nebraska are classified as health service shortage areas. Distance to services is particularly problematic in the sparsely populated rural areas of the state. There is considerable evidence that other groups identified above consider their health services to be inadequate and/or inappropriate in some respects. Elimination of these health service and health outcome disparities requires that we find ways to deliver the full range of health related services in culturally and linguistically appropriate ways to people in Nebraska where they live and work.

Women not only face barriers to services because of the circumstances listed above, they also are hampered by a health system that often is not “women’s health-friendly.” Insurance carriers often don’t have the same reimbursement policies for certain women’s services as for other similar services. Some women feel that the providers they encounter do not respect them, fail to listen to them, and do not understand their health needs.

There is a lack of adequate health professional training and awareness of women’s health issues, including how they impact women and their use of services. The current system lacks financial

and other incentives for professionals to provide services to women in an acceptable, sensitive manner. Furthermore, the interrelationships among health problems present a need for trainings that are broader both in topics and in the range of professionals they reach. This broad-based approach to training is particularly important in the areas of domestic violence and sexual assault.

Women's access to appropriate services is limited also by a lack of support systems for professionals who provide women's health services and a lack of women in health provider and health administration responsible positions.

Strategies to Increase Access to Culturally & Linguistically Appropriate Health Services

The New Dimensions Partnership identified the following strategies, the first three of which were selected as priorities for the 2004-05 planning period and are discussed more fully below:

- **Put services where people live and work that are reflective of the local cultures.**
- **Increase the number of racial/ethnic minority and rural health care providers.**
- **Educate providers about the cultural dimensions of healthcare and encourage the implementation of CLAS standards (Culturally and Linguistically Appropriate Services).**
- Integrate non-traditional, culturally diverse approaches to health care with traditional practices.
- Facilitate collaboration and pooled funds for document translations and interpreters.



- Get the word out about health promotion and services through a marketing campaign engaging local champions.
- Increase the availability of resource personnel and information for making referrals from providers (websites, literature, etc.).
- Ask women what they want and need to feel heard and respected.
- Encourage the education of providers who are interested in women's health in a comprehensive way: "All health issues women have are women's health issues."
- Educate providers that failing health is not a "natural" part of aging.

Put services where people live & work that are reflective of the local cultures

To the extent possible offer health services in the communities where people live and in their workplaces:

- Ensure that women across the state have local access to a basic set of essential health services.
- Put health services in local community centers, schools, and centers serving minority group populations.
- Encourage the partnership of health providers and employers to offer health services at worksite locations.

The placement of services in local communities and workplaces is a key to overcoming access barriers due to rural location and hours of service. Furthermore, by placing services in a culturally familiar environment, we facilitate efforts to provide culturally and linguistically appropriate services.

Increase the number of racial/ethnic minority & rural health care providers

Racial/ethnic minority groups are significantly underrepresented among health service providers in Nebraska, hindering efforts to provide culturally competent services to members of those groups. Rural communities have difficulty recruiting health providers because few of them have a rural background and interest in living in such areas. In order to address both of these shortages we should:

- Recruit racial/ethnic minority and rural health providers starting at the middle school level, taking advantage of existing programs that mentor students.
- Improve reimbursement rates to end inappropriate disparities based on geographic location.
- Improve financial and academic incentives and community attitudes to encourage students to stay in Nebraska for training and service.
- Facilitate the re-licensing of immigrants who have been trained and certified in other countries.
- Identify ways to welcome and integrate new people providing health care in our communities instead of treating them like outsiders.



Educate providers about the cultural dimensions of health care and facilitate the implementation of CLAS standards

Nebraska's increasingly diverse population means that many health providers serve patients whose culture is unfamiliar to them, and there may be no one in the provider's office who speaks the patient's primary language well enough for effective communication. Although the communication barriers due to different languages might be obvious, the cultural barriers are often hidden or misunderstood. Many providers need a better understanding of how their patients' cultural background affects their beliefs about disease, what they consider to be a health problem, how they communicate their health concerns, what kinds of treatment would be acceptable, and other related cultural attitudes.

"Distance is a problem. We have to drive to other communities for health care. Most clinics are not open after 4 or 5 so you have to take off work for health care and most cannot afford to take off work."

*- Nebraska Women's Health Survey
Respondent*

National standards for Culturally and Linguistically Appropriate Services (CLAS) in health care were issued by the U.S. Department of Health and Human Services Office of Minority Health (OMH) in December 2000. These standards are an important tool for addressing many aspects of this issue and it is expected that they will be fully implemented in Nebraska as required. However, among the 14 standards, only the four dealing with language access services are mandatory for recipients of Federal funds. Most of the others are

guidelines that OMH recommends for adoption by Federal, state, and national accrediting agencies. The standards are primarily directed at health care organizations, although individual providers are encouraged to use them.

Educational and advocacy efforts are needed to ensure the effective and widespread implementation of all the CLAS standards across Nebraska:

- Educate organizations and providers about the importance of culturally and linguistically competent health services.
- Provide information on resources to facilitate implementation (websites, literature, allied services).
- Disseminate best practice guidelines and models for implementation.
- Provide information and resources for all the standards, not just the mandated ones.



NHHSS Short-term strategies: The internal strategic planning team for women's health identified the following short-term and longer-term strategies that pertain to increasing access to appropriate health services.

- Create a central information source on women's health interpreters and translators (language, vision and hearing impaired) for all programs to access.
- Explore a connection to the Southeast Community College Interpreter / Translation program.
- Develop a joint Request for Proposals for health interpreters and translators, sharing contractors.
- Identify and revamp a list of current resources and contractors.
- Share names of people with cultural and linguistic competencies to participate on advisory councils as experts, resources, etc.
- Develop a common client referral tool that determines the client's needs and issues and is then used to refer them to the appropriate programs and services.
- Develop a program eligibility informational website to be accessed by the public and providers.

NHHSS Longer-term strategies: The internal strategic planning team for women's health identified the following longer-term strategies that pertain to increasing access to appropriate health services.



- Determine a set of agreed upon women's health outcomes with associated performance standards.
- Assess attitudes of caregivers and providers – include assessments on cultural competency, ageism, sexism, and sensitivity to disability.
- Begin collecting women's stories regarding women's health issues, needs, and outcomes.
- Develop a mechanism that provides every client (no matter what program they are enrolled in) with health information relevant to his or her phase in life.
- Create a Women's Health Registry that would track and report women's health status across the state.
- Develop a unified marketing plan for women and priorities. The plan would strive to take a proactive stand on new issues, messages, and technology.
- Examine the REAL Choices program (a self-directed care program) to determine if it should be replicated.

Stigma, Fear, & Taboos around Certain Health Issues

There are a number of health problems that have historically carried a stigma in our society that blames the patient or victim or unjustifiably labels them as a danger to others. Among these issues are addictions to alcohol, tobacco, or other substances; obesity; victim of sexual assault or domestic violence; sexually transmitted diseases, and mental illness.

Stigmas can produce fear among women about the consequences of acknowledging or addressing any of these problems. These fears include loss of child custody, loss of job, alienation of friends and family, or ruining of doctor/patient relationship. While men might be subject to the same consequences, the stigmas and the fears evoked are particularly strong for women, especially mothers.

There are other health issues for which there are strongly held, differing viewpoints that in some instances have become so polarizing that civil discussion and debate are often stifled. These controversial issues include, among others, abortion, sex education, condom distribution, adolescent sex, non-marital births, sexual orientation, stem cell research, drug needle exchange programs, assisted suicide, and subsidized health services for undocumented immigrants.

Additionally, there are other hidden issues that aren't freely discussed because of a reluctance to acknowledge the existence, magnitude, or seriousness of the problem; including child abuse, elder abuse, incest, and pedophilia.

The unwillingness to recognize and discuss certain controversial or hidden issues limits the opportunity for Nebraskans to make informed public policy choices. It also interferes with the provision of some needed services because organizations cannot or will not apply for program funding in these taboo areas.



Strategies to Reduce Stigmas, Fears & Taboos

The New Dimensions Partnership identified the following strategies, the first two of which were selected as priorities for the 2004-05 planning period and are discussed more fully below:

- **Increase the level of discussion and awareness on women's health issues affected by stigmas and taboos.**

- **Encourage and enable providers to address the broad array of women's health issues more fully.**
- Develop and implement a long-term strategy to address violence and assault issues (incorporating, for example, Project Harmony, a media campaign, the clergy).
- Make the media more responsible for its coverage of violence (e.g., when and how it is reported, victim identity, blaming the victim, ignoring offenders, ignoring violence against poor women).
- Expand pre-conception counseling in schools and churches in order to reduce adult diseases and decrease neural tube and other birth defects.
- Address obesity with non-judgmental discussion of the issue and exploration of realistic solutions, recognizing the influence of cultural attitudes and its impact on self-esteem and many other health issues.

Increase the level of discussion & awareness on women's health issues affected by stigmas & taboos

Nebraska's approach to the health issues that carry stigmas or taboos needs to shift from whispers in closets to frank, open discussions in the main public arena. We need to end the silence. A broad-based partnership of health service providers could lead such an effort.

It is particularly important that we reach girls at a young age to erase stigmas and prevent fear over issues that are important to their healthy development. We should expand the use of existing programs and tools designed for this purpose.

The implementation of this strategy would produce the following benefits:

"That happens a lot here, where middle aged people aren't quite old enough for Medicare - they have no dependents-so they can't get nothing here, yet they are so sick they can't work, and there's no way to insure them."

- Nebraska Focus Group Respondent

- Health system changes that more freely and effectively address these issues
- Public policy changes based on more accurate information
- Women consumers empowered more to address their own problems in these areas

Encourage & enable providers to address the broad array of women's health issues more fully

The current system presents a number of obstacles and lacks adequate incentives for providers to address health issues for women outside their particular specialty area, especially those that are stigmatized or taboo subjects.

Payment structures for providers have the effect of limiting time for broad-based screening, prevention, and counseling. It needs to be demonstrated to both health coverage providers and health care providers that women's health would be improved if coverage were provided for broad-based screening and counseling services. Providers need to be pro-active in encouraging women to raise health issues that concern them. For example, appointment schedulers could ask if the patient needs additional time to discuss any problems. Practitioners could ask patients if they have anything else they wish to discuss. Providers could utilize computerized information technology to expand their screening, educational, and referral resources.

Specialized and isolated services make it difficult for women to request and access the help they need without fear of the consequences. Services need to be broadened, under a one-stop shopping model, to include those that address stigmatized and taboo health issues such as substance abuse and mental illness. These services should be made available at more diverse locations including, for example, major discount stores, shopping malls, and churches.

Lack of Mutual Support Systems for Women

Many Nebraska women have indicated the need for more women's mutual support groups that allow those with similar health issues to connect with and support each other. Current support systems are inadequate to meet the need and some are being discontinued due to budget cuts.

Support systems are particularly important with regard to healthy lifestyle issues: there is a disconnect between what women know to do and what they actually do. This problem impacts not only the woman's own health but also, as a caregiver, the health of her family. Mutual support groups can help women find the motivation and learn realistic strategies to make healthy choices. They can also help them resist the unhealthy options with which they are inundated through product advertisements.

Support groups are known to play an important role in women's recovery from serious life-threatening diseases, such as breast cancer. They can also benefit women in the management of chronic and debilitating health conditions. Support systems are effective channels for health promotion and outreach, as well as vehicles for shared information about programs and providers.



The need for mutual support systems has grown in part because of the changes in family dynamics and the labor market that have put more women in the workplace, often as a primary breadwinner. Nebraska has one of the highest percentages of working mothers in the nation. Between the demands of work and family, women are distanced from the traditional informal networks of mentoring and support they might have had in the past. Many Nebraska women are

also financially stressed due to the state economy, as well as unequal opportunities and pay inequities. Without a mutual support system, many women with limited time and financial resources find it very difficult to adopt healthy options for themselves and their families.

The change in family dynamics also means that adolescent girls and young women are not receiving the degree of mentoring and support they need to adopt healthy lifestyles. Poor choices at a young age can have a long-term impact on a woman's health. More cross-generational mentoring and support programs are needed to reach young females during their critical development years.

Strategies to Increase Women's Mutual Support Systems

The New Dimensions Partnership identified the following two broad strategies as priorities for the 2004-05 planning period:

- **Engage and assist communities to develop and improve mutual support systems for women's health.**
- **Identify and expand on existing health support systems and models throughout the state.**

Engage & assist communities to develop & improve mutual support systems for women's health



This strategy seeks to identify and assist communities that are willing and able to develop or improve mutual support systems for women's health. In this instance, "community" is a place-based concept, including a neighborhood, town, city, county, region, or metropolitan area. A community's readiness to participate would be indicated by the presence of individuals with a passion for promoting women's health, and broad-based support among local government agencies, public and private organizations, and employers.

The community's mutual support system should be developed or enhanced based on a planning process that incorporates the following features:

- An assessment of women's health needs and available resources within the community
- Identification of existing support models and "best practices" to be implemented or expanded
- Identification of employers with women- and family-friendly workplace policies, including insurance, daycare, health coverage, flex-time
- Broad-based community discussions and focus groups

- The participation of women from all aspects of the community, including those in need of services and those who would help deliver services
- The identification of places where women work and gather as opportunities for planning and program implementation
- Involvement of local government agencies such as the health department, family planning and counseling agencies, and community action agencies
- Coordination with community services (e.g., transportation, translation) to avoid duplication
- Involvement of public and private organizations that are committed to the community such as schools, hospitals, banks, private employers, religious organizations, faith-based social services, and women's service and advocacy organizations

The programs to be implemented should include the following characteristics:

- Collaboration among government agencies, public and private organizations, and private employers
- Supportive connections among women within specific community groups as well as across diverse community groups
- Supportive connections among natural women leaders and women who could benefit from mentors
- Neighborhood-based initiatives that develop and extend existing family supports
- Promotion of mutual respect and self-esteem among women throughout the community
- A model for duplication in other communities

Identify & expand on existing health support systems & models throughout the state

Women's mutual support systems do not need to serve an entire community and do not necessarily need to be located in a specific place. Rather, they can be based on "affinity" groups of women who share common health needs, backgrounds, interests, age, or other characteristics. Often such groups operate in a specific location for the purposes of face-to-face meetings. Others operate in cyberspace through Internet connections.

Examples of existing support groups based on health needs are Weight Watchers, Alcoholics Anonymous, and cancer survivor programs. Support groups also exist for diseases such as diabetes and HIV.

Organization sponsors are needed to establish and expand on these existing programs in order to provide more mutual support opportunities on women's health issues across the state. Potential sponsors include women's service and advocacy organizations (YWCA, American Association of University Women, Business and Professional Women, League of Women Voters, Older Women's League), youth support organizations (Girl Scouts, Campfire, 4-H, Girls Inc., Girls and Boys Clubs), religious organizations (Interchurch Ministries, Parish Nurses, Health Ministries, Jewish Women's



League), community service agencies (Community Action Agencies, Area Agencies on Aging), cultural support organizations (Urban League, Latina Resource Center), and health service and advocacy groups (Nebraska Alliance for Mental Health, Planned Parenthood).

Inadequate Funding



The New Dimensions Partnership identified inadequate funding as a primary obstacle to meeting our health goals and objectives for women in Nebraska. Not only is there a lack of funding that supports women's health intervention programs, but also there is ineffectiveness in the way some funds are directed. Furthermore, health service reimbursements (e.g., Medicare, private health insurance) often are inadequate to cover the cost of providing the service. The public's preferences for additional services often conflicts with the ability of the public sector to pay for them.

The current funding pattern is a major contributor to the problem that the health system is crisis oriented and focused on short-term interventions instead of having a long-term prevention focus. This approach reflects a broader cultural focus on immediate gratification and an attitude that "this can never happen to me." Programs tend to follow the funding – and the funding is often short-term, and not directed toward long-term prevention goals:

- Short-term funding often goes away after a few years without providing maintenance funds for the long run.
- The 'hot' topic of the moment (e.g., West Nile Virus, SARS, bioterrorism) receives more funding than long-term, systemic issues.
- Funds that impact healthy behaviors such as good nutrition and physical activity are typically unavailable.
- Nebraska has historically ranked 49th out of 50 states in mental health and public health funding.

The rapidly rising cost of health care makes the lack of adequate funding a very salient obstacle to meeting our goals for Nebraska women's health.

Strategies to Improve Funding

The New Dimensions Partnership identified the following strategies, the first two of which were selected as priorities for the 2004-05 planning period and are discussed more fully below:

- **Develop an integrated approach to the use of existing resources.**
- **Make a case for new resources for women's health.**

- Provide ongoing announcements and information on federal grants and other monies available.
- Share and replicate best practices and programs – do not duplicate.
- Develop collaborations on grant proposals and projects.
- Implement web-based methods for better communication among organizations regarding their activities, especially public health agencies.
- Establish a dedicated fund for women’s health in Nebraska.
- Channel money through local health districts for better coordination and use of existing funds.
- De-regionalize community based care to better use the funds we have.

Develop an integrated approach to the use of existing resources

Existing resources could be used more effectively for women’s health under an integrated approach that takes a comprehensive view of funding for public and private sector programs at both state and local levels. This approach would facilitate the identification of major funding/program gaps as well as unnecessary duplication. It would also reveal where resources are available to leverage additional funding.

To implement an integrated funding approach, the following steps would need to be taken:

- Identify and assess current funding streams.
- Match current funding to issues and needs in the plan.
- Use existing resources to leverage new dollars.

Make a case for new resources for women’s health

Adequate funding for women’s health cannot be achieved without a concerted effort to convince funders of the need for new resources, especially in the area of primary prevention.

More attention needs to be paid to outcome and performance measures that can demonstrate the effectiveness of the approaches that need additional funding. The Nebraska Health and Human Services System could provide resources to assist nonprofit organizations in the collection of program evaluation data. A Legislative Day could be held to better educate legislators on women’s health issues and the investments required to support needed services. The case for new resources also should be made to private individuals and foundations.

“I have to space health services out due to financial barriers. My kids get first priority, so things that aren’t critical have to wait. Even with good insurance, there is a cost to everything and if it is anything significant (e.g., surgery, CAT scan, etc.) it costs hundreds of dollars.”

- Nebraska Women’s Health Survey Respondent

The New Dimensions Partnership recommended that the case be made to the legislature for adequate and equitable health care reimbursement policies, including the following measures:

- Require cost-based reimbursement.
- Ensure that women's health is covered at the same rate as men's and children's health care, including mental and dental health.
- Mandate coverage of preventive health services.

They also recommended exploring potential sources of additional revenues to support women's health services, including:

- New taxes on junk food, tobacco, alcohol, pop, and other "unhealthy" products
- Surcharges on health profession licenses

NHHSS Short-term strategy: The internal strategic planning team for women's health identified the following short-term strategy that pertains to improving funding.

- Develop a funding information clearinghouse focused on women's health programs and services that includes opportunities to apply for external funds, grant application partnership opportunities, identification of which internal areas are applying for which grants, and a listing of funding offered by the state government to communities, other agencies, etc.

NHHSS Longer-term strategies: The internal strategic planning team for women's health identified the following longer-term strategies that pertain to increasing access to appropriate health services.

- Identify ways to use state Medicaid administration money to support women's health.
- Form a consortium with pooled resources that could examine the development of comprehensive women's health clinics across the state, universal coverage, and ways to access other funding sources.
- Focus on preventive health programming and services for women.

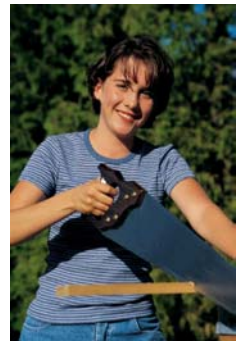


Plan Implementation

Implementation of the Women's Health Plan requires specific actions to carry out the strategies that were identified to address priority issues and help achieve its goals. New Dimensions of Health for Nebraska Women Partnership members and the Nebraska Health and Human Services System internal planning group developed a number of action steps. Project staff further refined these steps and established timelines. Many of these action steps address multiple priority issues.

First Year Action Steps

1. Inventory financial resources and available categorical funding streams of programs within the Nebraska Health and Human Services agency to find common priorities related to the CLAS (Culturally and Linguistically Appropriate Services) requirements and to determine any restrictions that would inhibit working with other programs on cooperative projects. Develop a plan for training staff in participating programs and a financial plan to provide technical assistance to partners, sub grantees, and other community agencies.
2. Using the results of Action Step #1 as a model, inventory priority issues of Nebraska Health and Human Services agency programs to determine corresponding goals and priorities. Develop a matrix of opportunities and a coordinated action plan and financial plan.
3. With funding from the Health Resources and Services Administration women's health grant, fund three pilot communities to develop integrated, coordinated women's health services that include initiatives to identify and further develop support systems for women, develop best practices and improved service linkages, disseminate women's health promotion messages, and develop shared expectations and standards for cultural competence. Develop and implement evaluation strategies so that results from these pilot programs can be shared with other communities interested in improving women's health services.



4. Within the Nebraska Health and Human Services agency, create a central information source on women's health interpreters and translators (language, vision, and hearing impaired) for all programs to access.

5. In collaboration with Partnership members, develop a campaign to help women understand how to advocate for high quality health care for themselves. Disseminate this campaign through media, policy-makers, organizations that are interested in women's advocacy, and non-traditional partners. Publish the messages in multiple languages, utilizing principles of cultural competency. Examine ways to include advocacy for increased educational opportunities for women as a means to increase economic self-sufficiency.

Action Steps for Years Two through Five

1. Create and disseminate resources to provide technical assistance and increase communication among the Nebraska Health and Human Services System and local health departments, health care providers, and other organizations providing services to women. These may include:
 - Guidelines/standards of basic public health services
 - Fact sheets with frequently asked questions from local health departments
 - Board of health training on the importance of different aspects of public health; i.e., environmental factors, minorities, women's health
 - Newsletters for providers
2. In collaboration with Partnership members and other providers across the state, develop a comprehensive web-based Community Resource Directory, with translations in Spanish, Vietnamese, and other languages. Include existing systems of mutual support for women's health issues. Disseminate information on the Directory to women throughout the state.
3. Organize a state task force to develop a web-based confidential screening tool for health referrals (substance abuse, mental health, violence, domestic abuse, disease risk, etc.), with links to local resources. Design the tool so that it will be customized to women with different demographic characteristics.
4. Working with churches and other partners, increase the availability of support groups for women on various health issues, and expand walking groups for women as a way of providing mutual support. Explore the feasibility of providing support groups on the Internet (chat rooms) with monitoring by health professionals to assure accurate information.
5. Incorporate a wellness program into a living unit at the women's prison and evaluate the program. Develop a system to assure that women are connected with community resources upon release.
6. In collaboration with Partnership members, organize a publicity campaign on women's health issues. Increase the frequency of women's health messages on television and radio, and develop community speakers' bureaus on women's health.



The following table summarizes the action steps and their relationship to these priority issues: isolation within the overall health services system; inadequate access to appropriate health services; lack of mutual support systems for women; stigma, fear and taboos around certain health issues; and inadequate funding.

Action Step	Priority Issues				
	Isolation	Access	Support	Stigma	Funding
First Year Action Steps					
1. Inventory financial resources in support of CLAS requirements	*				*
2. Develop matrix of opportunities	*				*
3. Fund three pilot communities	*	*	*		
4. Information on interpreters and translators		*			
5. Develop campaign for women's health advocacy		*		*	
Action Steps for Years Two through Five					
1. Create and disseminate resources for local health departments, providers and others	*	*	*		*
2. Develop web-based Community Resource Directory	*	*	*		
3. Develop web-based screening tool for health referrals	*	*		*	
4. Increase availability of support groups			*		
5. Incorporate wellness program at the women's prison	*	*	*	*	
6. Organize publicity campaign on women's health issues	*			*	

Evaluation

Substantial, measurable improvement in Nebraska women's health is the ultimate criterion against which the Nebraska Women's Health Plan needs to be evaluated. However, that achievement cannot be expected by June 30, 2005, the end of the current grant. Instead, the initial plan evaluation will be based on the following related processes:



- Effective implementation of the initial action steps of this Plan
- Enhanced integration of NHHSS programs related to women's health
- Extensive collaborative participation among the New Dimensions of Health for Nebraska Women Partnership

Continuity

The current plan identifies first year action steps and steps for years two through five. It is anticipated that the action steps will be reviewed annually by NHHSS and the Partnership to make any appropriate adjustments. A thorough review of the plan's goals and strategic objectives will be undertaken approximately every five years.



Resources

2002 Kids Count in Nebraska. Voices for Children in Nebraska, Omaha, NE, 2003.

A Century of Women's Health 1900-2000. US Department of Health and Human Services, Office on Women's Health, Washington, DC, April 2002.

A National Public Health Initiative on Diabetes and Women's Health, Interim Report: Proposed Recommendations for Action. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Atlanta, GA, 2002.

Across the States, Profiles of Long-Term Care, AARP Public Policy Institute, Washington, DC, 2002.

America's Bone Health: The State of Osteoporosis and Low Bone Mass in Our Nation. National Osteoporosis Foundation, Washington, DC, 2002.

Asthma in Nebraska, Nebraska Epidemiology Special Report, Nebraska Health and Human Services System, Lincoln, NE, March 2001.

Cancer Incidence and Mortality in Nebraska, 1999. Nebraska Cancer Registry 1999 Annual Report, Nebraska Health & Human Services System, Department of Regulation and Licensure, Lincoln, NE, June 2002.

Census 2000 Summary File 3(SF 3) Sample Data. U.S. Census Bureau, retrieved from www.census.gov.

Centers for Disease Control and Prevention. National Center for Health Statistics. Healthy Women: State Trends in Health and Mortality, retrieved from <http://www.cdc.gov/nchs/healthywomen.htm>.

Crime in Nebraska 2000: Uniform Crime Reports. Nebraska Commission on Law Enforcement and Criminal Justice, Lincoln, NE.

Critical Access Hospitals: Nebraska's Story. Nebraska Department of Health and Human Services, Office of Rural Health, Lincoln, NE, September 2002.

Current Population Survey, Annual Demographic Supplement (Poverty 2001), Bureau of Labor Statistics and U.S. Census Bureau, retrieved from www.census.gov.

Diabetes Among Racial and Ethnic Minorities in Nebraska 1992-2001. Onyema G. Knwocha, Office of Minority Health and Human Services, Nebraska Department of Health and Human Services.

Every Child Welcomed, Nurtured and Supported Steering Committee: Report of Recommendations, Nebraska Department of Health and Human Services, December 2001.

Every Woman Matters Program, Nebraska client profile, 7/21/2002 to 7/21/2003, Nebraska Department of Health and Human Services, Office of Women's Health, July 2003.

Geriatrics and Mental Health – The Facts. American Association for Geriatric Psychiatry, Bethesda, MD, 2002, retrieved from www.aagponline.org, July 2003.

Guidelines for Comprehensive Programs to Promote Healthy Eating and Physical Activity. Nutrition and Physical Activity Work Group, Human Kinetics, Champagne, IL, 2002.

Health Services at Risk in Vulnerable Places, *Michael D. Shambaugh-Miller, et.al., Rural Policy Brief*, Vol. 7, No. 5, RUPRI Center for Rural Health Policy Analysis, Omaha, NE, October 2002.

Health Status of Racial and Ethnic Minorities in Nebraska. Nebraska Health and Human Services System, Office of Minority Health and Human Services, Lincoln, NE, April 2001.

Health Survey of Gay, Lesbian, Bisexual, and Transsexual Women: Summary of Results, Every Woman Matters Program, Nebraska Health and Human Services System, Lincoln, NE, June 2001.

Heart Disease Among African Americans in Nebraska, 1979-1999. Nebraska Health and Human Services System, September 2002.

HRSA State Health Workforce Profile: Nebraska. Health Resources and Services Administration, Rockville, MD, US Department of Health and Human Services, December 2002.

Minority Behavior Risk Factor Survey, Hall County, Nebraska. Nebraska Department of Health and Human Services, Office of Minority Health and Human Services, August 2001.

Minority Health Information, Nebraska Health and Human Services System, Office of Minority Health and Human Services, Lincoln, NE, September 2002.

National Standards for Culturally and Linguistically Appropriate Services in Health Care. U.S. Department of Health and Human Services, Office of Minority Health, December 2002, retrieved from www.omhrc.gov/clas/, July 2003.

National Study of Women with Physical Disabilities. Nosek, M.A., et. al. Center for Research on Women with Disabilities. Baylor College of Medicine, Huston, TX, 1997.

Nebraska 2002 Annual Report for OPA Title X Family Planning Program Grantees. Nebraska Health and Human Services System, Office of Family Health, February 2003.

Nebraska 2010 Health Goals and Objectives, Nebraska Health and Human Services System, Lincoln, NE, May 2002.

Nebraska AARP Prescription Drug Survey, Anita Stowell-Ritter, AARP Knowledge Management, Washington, DC, 2002.

Nebraska Adolescents: Major Causes of Premature Death and Disability, 2001. Nebraska Health and Human Services System, Office of Chronic Disease and Health Promotion, Lincoln, NE, August 2002.

Nebraska Behavioral Risk Factor Surveillance System Report, 1995-1996. Nebraska Department of Health and Human Services.

Nebraska Behavioral Risk Factor Surveillance System Report, 1999-2000. Nebraska Health and Human Services System, February 2003.

Nebraska Home and Community-Based Care Survey, Anita Stowell-Ritter, AARP Knowledge Management, Washington, DC, 2002.

Nebraska MCH Priority Needs Report. Nebraska Health and Human Services System, Division of Family Health, April 2001.

Nebraska Mental Health Statistics Improvement Program: Prevalence, Utilization and Penetration. Nebraska Department of Health and Human Services, Division of Mental Health, Substance Abuse and Addiction Services, October 2001.

Nebraska Needs Assessment: Title X Family Planning Program Application, Nebraska Health and Human Services System, Office of Family Health, March 2001.

Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) 1999 Data Book. Nebraska Health and Human Services System, Office of Family Health, Lincoln, NE, July 2002.

Nebraska State Demand and Needs Assessment Studies: Alcohol and Other Drugs: Adult Household Survey Results. Bureau of Sociological Research, University of Nebraska at Lincoln and Nebraska Health and Human Services System, Lincoln, NE, 2001.

Nebraska State Demand and Needs Assessment Studies: Alcohol and Other Drugs: Youth Household Survey Results. Bureau of Sociological Research, University of Nebraska at Lincoln and Nebraska Health and Human Services System, Lincoln, NE, 2001.

Nebraska's Blue Ribbon Panel on Infant Mortality: Report to the Governor. Nebraska Health and Human Services System, October 2000.

Need Estimate for Substance Abuse Treatment, 2000. Nebraska Health and Human Services System, Division of Mental Health, Substance Abuse and Addiction Services. Retrieved from www.hhss.state.ne.us, May 2003.

Saving Lives in Nebraska: Cancer Facts & Figures 2000-2001. Nebraska Health and Human Services System and American Cancer Society, Heartland Division Inc.

Selected Questions from the Kaiser Women's Health Survey, Henry J. Kaiser Family Foundation, Menlo Park, CA, May 2002, retrieved from www.kff.org, February 2003

State Action Kit: A Strong Woman's Guide to Fighting Osteoporosis Through Advocacy. Strong Women Inside and Out, Washington, DC, 1997.

State-Specific Prevalence Estimates of Uninsured and Underinsured Persons--Behavioral Risk Factor Surveillance System, 1995, *Morbidity and Mortality Weekly*, January 30, 1998, 47(03): 51-55, Centers for Disease Control, retrieved from www.cdc.gov/mmwr.

Statistics Compiled from Nebraska Domestic Violence/ Sexual Assault Programs, Nebraska Domestic Violence Sexual Assault Coalition, Lincoln, NE, 2001.

The Unmet Needs of Nebraska's Older Adults for Aging Services, Nebraska Association of Area Agencies on Aging, Lincoln, NE, 2003.

Understanding the Relationship between Domestic Violence, Sexual Trauma Services, and Behavioral Health Treatment in Nebraska: A Needs Assessment Study. Denise C. Herz, et. al., University of Nebraska at Omaha, Department of Criminal Justice, Omaha, NE, 2003.

Unspoken Crimes: Sexual Assault in Rural America. Susan H. Lewis, National Sexual Violence Resource Center, Pennsylvania Coalition Against Rape, Enola, PA, 2003.

Women and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality. Michel M. Casper, et. al., Office for Social Environment and Health Research, West Virginia University, Morgantown, WV, 1999.

Women's Health in the United States: Health Coverage and Access to Care. Kaiser Women's Health Survey, Henry J. Kaiser Family Foundation, Menlo Park, CA, May 2002.

Women's Health USA 2002. US Department of Health and Human Services, Health Resources and Services Administration, Rockville, MD, 2002.

Women's Voices: Finding Solutions. Lincoln-Lancaster Women's Commission. Lincoln, NE, 2003.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE • DEPARTMENT OF FINANCE AND SUPPORT